



County of San Diego

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HIV/AIDS Services
Medical Quality Assurance
Public Health Laboratory
PH Nursing/Border Health
TB & STD Control
Vital Records

May 15, 2003

TO: Basic and Advanced Life Support Provider Agencies
Base Hospital Nurse Coordinators
Base Hospital Medical Directors
EMT-Paramedic Training Program Coordinators

FROM: Gary Vilke, MD, FACEP, FAAEM
Interim Medical Director
Division of Emergency Medical Services

NEW/REVISED 2003 EMERGENCY MEDICAL SERVICES TREATMENT PROTOCOLS/POLICIES

For the past year, many committees have been working to update the policies and protocols contained within the County of San Diego Emergency Medical Services Policy and Procedure Manual. We are pleased once again to present the complete manual on CD ROM. There is an additional CD ROM available to approved Continuing Education Training Providers that contains a training presentation on the new adult (S-141) and pediatric (S-173) pain management protocols.

Listed below you will find a list of the prehospital system (S series) ALS/BLS protocols affected by July 1, 2003 changes. A summary of ALS/BLS treatment reviews and changes is included on the CD ROM. All of the defibrillation policies have been updated to reflect regulatory changes. The major impact is the elimination of defibrillation continuing education requirements for EMT-Basic as defibrillation is now part of the EMT-Basic Scope of Practice. The table of contents reflects the documents that have been updated, added or deleted for July 1, 2003 implementation.

- **Revised ALS/BLS Treatment Protocols and Policies:**

S-101 Glossary of Terms

S-103 BLS/ALS Ambulance Inventory

P-104 ALS Skills List

P-110 ALS Adult Standing Orders

P-111 Adult Standing Orders for Communications Failure

- P-112 Pediatric ALS Standing Orders**
- P-113 Pediatric Standing Orders for Communications Failure**
- P-115 ALS Medication List**
- P-117 ALS Pediatric Drug Chart**
- S-121 Airway Obstruction**
- S-122 Allergic Reaction/Anaphylaxis**
- S-123 Altered Neurologic Function**
- S-124 Burns**
- S-126 Discomfort/Pain of Suspected Cardiac Origin**
- S-127 Dysrhythmias**
- S-129 Envenomation Injuries**
- S-133 Obstetrical Emergencies**
- S-134 Poisoning/Overdose**
- S-135 Pre-existing Medical Interventions**
- S-136 Respiratory Distress**
- S-138 Shock**
- S-139 Trauma**
- S-141 Pain Management **NEW****
- S-150 Nerve Agent Exposure**

PEDIATRIC PROTOCOLS:

- S-160 Airway Obstruction**
- S-161 Altered Neurologic Function**
- S-162 ALS/Allergic Reaction**
- S-163 Dysrhythmias**
- S-164 Envenomation Injuries**
- S-165 Poisoning/Overdose**
- S-166 Newborn Deliveries**
- S-167 Respiratory Distress**
- S-169 Trauma**
- S-170 Burns**
- S-171 Cardiac Arrest (Unmonitored non-traumatic)**
- S-173 Pain Management **NEW****

Please replace earlier copies of your EMS Policy Manual with the updated documents. Contact Merle Rupp at the EMS Division for questions related to documents in the EMS System Policy Manual.

Thank you.



Gary Vilke, MD, FACEP, FAAEM
Interim Medical Director
Division of Emergency Medical Services

GV:MM
Enclosure



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June 26, 2003

TO: Advanced Life Support Provider Agency Coordinators
Basic Life Support Agency Coordinators
Base Hospital Nurse Coordinators
Base Hospital Medical Directors
EMT-Paramedic Training Program Coordinators

From: Gary M. Vilke, MD, FACEP, FAAEM
Interim Medical Director
Division of Emergency Medical Services

UPDATES/CORRECTIONS TO JULY 2003 PROTOCOL AND POLICY REVISIONS

While we have tried very hard to avoid updates/corrections to July 2003 protocols that were distributed in the July 2003 policy/protocol CD Rom, it has come to our attention that the pediatric drug chart (P-117) and the adult standing orders (P-110) were in need of updates before July 1, 2003.

P-117 has been modified to clarify the Atropine dosages in bradycardia and OPP. This was done because the atropine dose in the patient ≥ 50 kg is 1 mg for bradycardia and 2 mg for OPP, and this was not clear in the original table.

Please also note that the Atropine IM dose in OPP for a ≥ 50 kg child is 2 mg of the 0.4mg/1ml concentration. There is an asterisk to alert prehospital staff to divide the dose into two 2.5 ml injections.

Additionally, the morphine IV / IM dosages have been rounded for easier administration.

P-110 has been modified adding Stable VT to Lidocaine Standing Orders.

The Master List (Table of Contents) has been updated to reflect the revisions.

Please take the opportunity to review the updates with your staff. Thank you.

GARY M. VILKE, MD, FACEP, FAAEM

GMV:MM:bb

**County of San Diego Health and Human Services
Division of Emergency Medical Services**

Date: 5/15/03
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**SUMMARY OF REVIEW/CHANGES TO
ALS/BLS TREATMENT PROTOCOLS
FOR
JULY 1, 2003**

	TREATMENT GUIDELINES AND PROTOCOLS															
S-100	Reviewed without changes															
S-101	Add definition of “opioid”															
S-102	Reviewed without changes															
S-103	<div><div>Changes to inventory:</div><table><thead><tr><th><u>Medication</u></th><th><u>Concentration</u></th><th><u>Minimum Quantity</u></th></tr></thead><tbody><tr><td>Midazolam (Versed)</td><td>5 mg/1 ml</td><td>20 mg</td></tr><tr><td>Naloxone HCL (Narcan)</td><td>1 mg/ 1 ml</td><td>6 mg</td></tr><tr><td colspan="3"><u>Add:</u></td></tr><tr><td>Morphine Sulfate IR</td><td>10 mg/5ml</td><td>3</td></tr></tbody></table></div>	<u>Medication</u>	<u>Concentration</u>	<u>Minimum Quantity</u>	Midazolam (Versed)	5 mg/1 ml	20 mg	Naloxone HCL (Narcan)	1 mg/ 1 ml	6 mg	<u>Add:</u>			Morphine Sulfate IR	10 mg/5ml	3
<u>Medication</u>	<u>Concentration</u>	<u>Minimum Quantity</u>														
Midazolam (Versed)	5 mg/1 ml	20 mg														
Naloxone HCL (Narcan)	1 mg/ 1 ml	6 mg														
<u>Add:</u>																
Morphine Sulfate IR	10 mg/5ml	3														
S-104	Add Pain Scale															
S-105	Reviewed without changes															
D-108	Reviewed without changes															
D-109	Reviewed without changes															
P-110	Changed to match new <u>SO</u>															
P-111	Changed Adult Standing Orders for Communication Failure to match revised protocols															
P-112	Changed to match new <u>SO</u>															
P-113	Changed Pediatric Standing Orders for Communication Failure to match revised protocols															
P-114	Reviewed without changes															
P-115	Add oral MS IR															
P-117	<div>Add dosages for:<ul style="list-style-type: none">• Epinephrine –Nebulized• Post conversion Lidocaine• Oral Morphine Sulfate IR• Sodium Bicarbonate</div>															

**County of San Diego Health and Human Services
Division of Emergency Medical Services**

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	ADULT PROTOCOLS
S120	Reviewed without changes
S121	Change note to read: If unable to secure airway, transport STAT while continuing abdominal thrusts.
S122	Format change
S123	Change narcotic to "opioid" Seizures Versed order: Change "OR" to "If no IV" Remove (1mg/min) from Versed administration.
S124	Change MS order to: Treat pain as per Pain Management Protocol (S-141)
S125	Reviewed without changes
S126	<p>BLS & ALS: Change BP parameter from ≥ 110 mmHg to ≥ 100 mmHg Change Protocol to: NTG 0.4mg SL <u>SO</u>. MR x2 q3-5" <u>SO</u>. MR q3-5" per BHO. NTG ointment 1" per <u>SO</u>. If NTG x 3 <u>SO</u> ineffective or contraindicated: MS 2-10mg in 2-4mg increments IVP to max of 10mg per SO</p> <p><i>If BP < 100 mmHg:</i> NTG 0.4mg SL per <u>BHPO</u>. MS 2-10 mg in 2-4mg increments IVP to max of 10mg per <u>BHPO</u></p> <p>ASA order: <i>delete "BHPO if pt. on anticoagulants."</i> <i>Delete Prophylactic Lidocaine</i></p>
S127	<p>Change SVT Protocol to: Delete CSM First dose of Adenosine to <u>SO</u> B. Supraventricular Tachycardia (SVT): Stable/Unstable (chest pain or dyspnea or BP <90mmHg or altered LOC): VSM per <u>SO</u>. MR per BHO.</p> <p>Adenosine 6mg rapid IVP, followed with 20ml NS IVP per <u>SO</u> (Patients with history of bronchospasm or COPD <u>BHPO</u>). Adenosine 12mg rapid IVP followed with 20ml NS IVP per BHO. MR x1 in 1-2" per BHO.</p> <p>If patient unstable and rhythm refractory to treatment or symptoms are severe: Conscious: Versed 1-5 mg slow IVP prn precardioversion per BHO. If age ≥ 60 consider lower dose with attention to age and hydration status Synchronized cardioversion at 100w/s (or clinically equivalent biphasic energy dose) per BHO; MR at 200, 300, 360 w/s (or clinically equivalent biphasic energy dose) per BHO</p> <p>Unconscious: Synchronized cardioversion at 100w/s (or clinically equivalent biphasic energy dose) <u>SO</u>. MR at 200, 300, 360 w/s (or clinically equivalent biphasic energy dose) per <u>SO</u>. MR per BHO</p> <p>For Uncontrolled Atrial Fib/flutter – add BP parameter to: Unconscious and BP < 90 mm Hg For Ventricular Ectopics – replace qualifier "in the Presence of Suspected Ischemia or Causing Decreased Cardiac output" with "Unstable" For Stable V-Tach, change first dose of Lidocaine to <u>SO</u> For Unconscious V-Tach, add for BLS, "AED, if available, may use."</p>

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S129	Delete ALS Snakebite section and Change MS order to: Treat pain as per Pain Management Protocol (S-141)
S130	Reviewed without changes
S131	Font change only, "FOR DEFINITIVE THERAPY ONLY"
S132	Reviewed without changes
S133	Eclampsia Versed order: Change "OR" to "If no IV"
S134	Change "narcotic" to "opioid." Replace range for Narcan when patient refuses transport with Narcan 2 mg IM <u>SO</u> . Symptomatic Organophosphate poisoning: Change Atropine to: Atropine 2mg IVP/IM MR q 3-5min x2 <u>SO</u> . MR q3-5" prn per BHO. OR Atropine 4mg ET, <u>SO</u> MR q 3-5 min x2 <u>SO</u> MR q3-5" prn per BHO Extrapyramidal reactions: Benadryl 50mg replaces range of 25-50mg.
S135	Change from BHO to <u>SO</u> for: If no medication label or identification of infusing substance, D/C per <u>SO</u>
S136	Change BP parameter from ≥ 110 to 100mmHG Increase MR NTG SL to 2x on <u>SO</u> Change Lasix to: 40mg or double daily dose to maximum of 100mg IVP <u>SO</u> MR to maximum of 100 mg total dose BHO
S137	Reviewed without changes.
S138	Change IV order in Normovolemic Shock to: IV wide open <u>SO</u> Move septic shock down to Shock (?cardiac etiology, septic shock)
S139	Change MS order to: Treat pain as per Pain Management Protocol (S-141)
S140	Reviewed without changes.
S141	NEW PROTOCOL: Pain Management
S150	Under "Severe" add "Initial dosing" and "doses in succession" for Atropine and 2-PAM CL Autoinjectors; Add "Ongoing treatment."

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	PEDIATRIC PROTOCOLS
S160	Change note to read: If unable to secure airway, transport STAT while continuing abdominal thrusts.
S161	Change narcotic to "opioid" Seizures Versed order: Change "OR" to "If no IV" Remove (1mg/min) from Versed administration.
S162	Format change
S163	BLS: Add "OR" between definition sections of Unstable Dysrhythmia and move heart rate parameters under the CPR statement. ALS: Add definition parameters of Unstable Bradycardia to ALS SVT: Delete CSM Change VSM to <u>SO</u> Asystole: Change language to read: "Pronouncement at scene or transport per <u>BHPO</u> ."
S164	Delete ALS Snakebite section and Change MS order to: Treat pain as per Pain Management Protocol (S-173)
S165	Change "narcotic" to "opioid." Change Atropine in Symptomatic OPP to <u>SO</u>
S166	BLS – add documentation of who cut the umbilical cord.
S167	ADD Respiratory Distress with Stridor: < 19 kg: Epinephrine 1:1,000 2.5ml via nebulizer <u>SO</u> ≥ 19 kg: Epinephrine 1:1,000 5ml via nebulizer <u>SO</u>
S168	Reviewed without changes.
S169	Change MS order to: Treat pain as per Pain Management Protocol (S-173)
S170	Change MS order to: Treat pain as per Pain Management Protocol (S-173)
S171	BLS add "If pt. ≥ 8 years, pulseless and AED is available, may use."
S172	Reviewed without changes.
S173	NEW PROTOCOL: Pain Management

**COUNTY OF SAN DIEGO
DIVISION OF EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES
Master List**

Policy Designators:	
A	Air Medical
B	EMT-1
D	EMT-D
N	Non Emergency Medical Transport
P	EMT-Paramedic
S	System - applies to all components of EMS system
T	Trauma Care System
L	Automatic External Defibrillator

000 - SYSTEMS

S-001	Emergency Medical Services System Compliance with State Statutes and Regulations (7/01)
S-002	Approval of Emergency Medical Services System Standards, Policies and Procedures (7/01)
S-003	Program Recordkeeping: Training and Certification (7/02)
S-004	Quality Assurance/Quality Improvement for the Prehospital Emergency Medical Services System (7/02)
S-005	EMS Medical Director's Advisory Committee (Base Station Physicians' Committee) (7/03)
S-006	Prehospital Audit Committee (7/01)
S-007	Transfer Agreements (11/91)
S-008	Interfacility Transfers - Levels of Care (7/02)
S-009	Guidelines for the Prevention of Infectious and Communicable Diseases (7/02)
S-010	Guidelines for Hospitals Requesting Ambulance Diversion (7/02)
S-011	Prehospital Emergency Medical Services Certificated Personnel Affected by Local EMS Disciplinary Action (3/90)
S-012	Prehospital Emergency Medical Care Investigative Process (3/90)
S-014	Guidelines for Verification of Organ Donor Status (7/01)
S-015	Medical Audit Committee on Trauma (7/02)
S-016	Release of Patient Information/Confidentiality (2/99)
S-017	Downgrade or Closure of Emergency Services in a Hospital Designated as a Basic Emergency Receiving Facility (7/03)

100 - TREATMENT GUIDELINES AND PROTOCOLS

SECTION I

S-100	Introduction (7/03)
S-101	Glossary of Terms (7/03)
S-102	List of Abbreviations (7/03)

Current policy number

(REV – Revised)

County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services

Master Policy List (7/03)

COUNTY OF SAN DIEGO
DIVISION OF EMERGENCY MEDICAL SERVICES
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SECTION II	Standing Orders/Medication List/Drug Chart Inventory/Skills
S-103	BLS/ALS Ambulance Inventory (7/03)
P-104	ALS Skills List (7/03)
S-105	Management of Latex Sensitive Patients & Latex-Safe Equipment List (7/03)
D-108	Emergency Medical Technician Defibrillation Automated External Defibrillator (AED) and Esophageal Tracheal Airway Device (ETAD) Standing Orders (7/03)
D-109	Emergency Medical Technician/Public Safety-Defibrillation Automated External Defibrillator (AED) Standing Orders (7/03)
P-110	Adult ALS Standing Orders (7/03) REV
P-111	Adult Standing Orders for Communications Failure (7/03)
P-112	Pediatric ALS Standing Orders (7/03)
P-113	Pediatric Standing Orders for Communications Failure (7/03)
P-114	Pediatric MICU Inventory (7/03)
P-115	ALS Medication List (7/03)
P-117	ALS Pediatric Drug Chart (7/03) REV
SECTION III	Adult Treatment Protocols
S-120	Abdominal Pain (Non-Traumatic) (7/03)
S-121	Airway Obstruction (Foreign Body) (7/03)
S-122	Allergic Reaction/Anaphylaxis (7/03)
S-123	Altered Neurologic Function (Non-Traumatic) (7/03)
S-124	Burns (7/03)
S-125	Cardiac Arrest Unmonitored (Non-Traumatic) (7/03)
S-126	Discomfort/Pain of Suspected Cardiac Origin (7/03)
S-127	Dysrhythmias (7/03)
S-129	Envenomation Injuries (7/03)
S-130	Environmental Exposure (7/03)
S-131	Hemodialysis Patient (7/03)
S-132	Near Drowning/Scuba Related Incidents (7/03)
S-133	Obstetrical Emergencies (7/03)
S-134	Poisoning/Overdose (7/03)
S-135	Pre-Existing Medical Interventions (7/03)
S-136	Respiratory Distress (7/03)
S-137	Sexual Assault (7/03)
S-138	Shock (7/03)
S-139	Trauma (7/03)
S-140	Triage, Multiple Patient Incident (7/03)
S-141	Pain Management (7/03)
S-150	Nerve Agent Exposure (7/03)
SECTION IV	Pediatric Treatment Protocols
S-160	Airway Obstruction (7/03)
S-161	Altered Neurologic Function (Non-Traumatic) (7/03)
S-162	ALS/Allergic Reaction (7/03)
S-163	Dysrhythmias (7/03)
S-164	Envenomation Injuries (7/03)
S-165	Poisoning/Overdose (7/03)
S-166	Newborn Deliveries (7/03)
S-167	Respiratory Distress (7/03)
S-168	Shock (Non-Traumatic) (7/03)
S-169	Trauma (7/03)
S-170	Burns (7/03)
S-171	ALS - Cardiac Arrest (Unmonitored non-traumatic) (7/03)
S-172	Apparent Life Threatening Event (7/03)
S-173	Pain Management (7/03)

Current policy number

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County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services

Master Policy List (7/03)

COUNTY OF SAN DIEGO
DIVISION OF EMERGENCY MEDICAL SERVICES
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Master List

200 - AIR MEDICAL TREATMENT PROTOCOLS

A-200	Introduction (7/03)
A-204	Skills List (7/03)
A-215	Medication List (7/03)
A-217	Pediatric Drug Chart (7/03)
A-220	Abdominal Pain (Non-Traumatic) (7/03)
A-221	Airway Obstruction (Foreign Body) (7/03)
A-222	Allergic Reaction/Anaphylaxis (7/03)
A-223	Altered Neurologic Function (Non-Traumatic) (7/03)
A-224	Burns (7/03)
A-225	Cardiac Arrest Unmonitored (Non-traumatic) (7/03)
A-226	Discomfort/Pain of Suspected Cardiac Origin (7/03)
A-227	Dysrhythmias (7/03)
A-229	Envenomation Injuries (7/03)
A-230	Environmental Exposure (7/03)
A-231	Hemodialysis Patient (7/03)
A-232	Near Drowning/Scuba (7/03)
A-233	Obstetrical Emergencies (7/03)
A-234	Poisoning/Overdose (7/03)
A-235	Pre-Existing Medical Interventions (7/03)
A-236	Respiratory Distress (7/03)
A-237	Sexual Assault (7/03)
A-238	Shock (7/03)
A-239	Trauma (7/03)
A-240	Triage, Multiple, Patient Incident (7/03)
A-241	Pain Management, Adult (7/03)
A-260	Airway Obstruction (7/03)
A-261	Altered Neurologic Function (Non-Traumatic) (7/03)
A-262	Pediatric ALS-Allergic Reaction (7/03)
A-263	Dysrhythmias (7/03)
A-264	Envenomation Injuries (7/03)
A-265	Poisoning/Overdose (7/03)
A-266	Newborn Deliveries (7/03)
A-267	Respiratory Distress (7/03)
A-268	Shock (non traumatic) (7/03)
A-269	Trauma (7/03)
A-270	Burns (7/03)
A-271	Cardiac Arrest Unmonitored (Non-Traumatic) (7/03)
A-273	Pain Management, Pediatric (7/03)

Current policy number

(REV – Revised)

County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services
Master Policy List (7/03)

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DIVISION OF EMERGENCY MEDICAL SERVICES
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300 - EDUCATION

P-300	EMT-Paramedic Training Program Student Eligibility (7/02)
P-301	EMT-Paramedic Training Program Requirements and Procedures for Approval (7/96)
P-303	Mobile Intensive Care Nurse Authorization/Reauthorization (7/00)
P-305	EMT-Paramedic Accreditation in San Diego County (7/03)
S-306	Designation of Authorized Providers of Continuing Education for Emergency Medical Services Personnel (7/02)
S-307	Continuing Education for Prehospital Personnel (1/95)
D-320	Defibrillation Training Program Student Eligibility (EMT/PS) (7/03)
D-321	Emergency Medical Technician/Public Safety-Defibrillation Training Program Requirements (7/03)
D-322	Emergency Medical Technician/Public Safety-Defibrillation Accreditation (7/03)
D-325	Esophageal Tracheal Airway Device Training Program Requirements (7/03)
B-326	Esophageal Tracheal Airway Device Student Eligibility (7/03)
B-327	Esophageal Tracheal airway Device (ETAD) Accreditation (7/03)
B-351	EMT Training Programs (7/02)
B-352	EMT-I Certification/Recertification (7/98)
L-360	Deleted (7/03)

400 - MEDICAL CONTROL

S-400	Management of Controlled Drugs on Advanced Life Support Units (7/03)
P-401	Scope of Practice of EMT-Paramedic in San Diego County (7/00)
S-402	Prehospital Determination of Death (7/03)
P-403	Physician on Scene (7/02)
P-405	Communications Failure (7/02)
A-406	Determination of Death (7/02)
S-407	Triage to Appropriate Facility (3/93)
P-408	Variation From San Diego County Protocols for Advance Life Support (7/02)
S-409	Reporting of Issues in Patient Care Management (7/03)
P-410	San Diego County Special Assignment - EMT-Paramedic (7/02)
S-411	Reporting of Suspected Abuse (7/01)
S-412	Consent for Prehospital Treatment and Transport (7/03)
S-414	Do Not Resuscitate - DNR (7/01)
S-415	Base Hospital Contact/Patient Transportation and Report (7/01)
S-416	Supply and Resupply of Designated EMS Agencies and Vehicles (7/01)
D-418	Emergency Medical Technician/Public Safety-Defibrillation Equipment (7/03)
D-420	Transfer of Specific Patient Care Information Between Emergency Medical Technician/Public Safety-Defibrillation and Transport Personnel (7/03)
D-421	Deleted (7/03)
S-422	Application of Patient Restraints (7/02)
L-430	Deleted (7/03)
L-431	Deleted (7/03)
P-440	Utilization of Nerve Agent Exposure Drugs (7/01)
B-450	Emergency Medical Technician-I Scope of Practice (7/03)
T-460	Identification of the Trauma Center Candidate (7/01)
T-460 (a)	Trauma Decision Tree Algorithm (7/01)
A-475	Air Medical Support Utilization (7/02)

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County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services

Master Policy List (7/03)

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600 - DATA COLLECTION

S-601	Communication and Documentation of Prehospital Patient Care Information (7/01)
D-620	Emergency Medical Technician/Public Safety-Defibrillation Data Collection and Evaluation (2/99)
D-621	Transfer of Patient Data/Medical Record (2/99)
D-622	Esophageal Tracheal Airway Device Data Collection and Evaluation (2/99)
L-624	Deleted (7/03)

700 - BASE HOSPITAL/TRAUMA CENTER

P-701	EMT-Paramedic Base Hospital Designation (7/98)
P-702	Dedesignation of an EMT-Paramedic Base Hospital (7/98) REV
T-703	Trauma Care Fund (7/02)
T-705	Trauma Catchment Service Area (7/02)
T-706	Role of the Pediatric Trauma Center (7/02)
T-708	Trauma Care Coordination Within the Trauma System (7/02)
T-710	Designation of a Trauma Center (7/02)
T-711	De-designation of a Trauma Center (7/02)
T-712	Trauma Center Bypass (7/02)
T-713	Resources for Trauma Team Response (7/02)
T-714	Trauma Service Consultations for the Community (7/02)
T-716	Transfer of Stable Trauma Service Health Plan Members (7/02)
T-717	Trauma Center Injury Prevention Activities (7/02)
T-718	Public Information & Education on Trauma Systems (7/02)
T-719	Trauma Provider Marketing and Advertising (7/02)
D-720	EMT/PS-D Base Hospital Designation (3/91)
D-721	Quality Assurance for Emergency Medical Technician/Public Safety-Defibrillation (2/99)

800 - SERVICE PROVIDER AGENCY

P-801	Designation of Providers of Advanced Life Support Service (11/96)
S-803	Recovery of Prehospital Patient Care Reusable Equipment (7/99)
P-804	Alternate EMT-Paramedic Service Provider Application/Designation (9/91)
P-805	Advanced Life Support First Responder Units (7/97)
P-806	Advanced Life Support First Responder Inventory (7/02)
D-820	Emergency Medical Technician/Public Safety-Defibrillation Service Provider Designation (7/03)
D-822	Esophageal Tracheal Airway Device Service Provider Designation (2/99)
S-830	Ambulance Provider's Permit Application Process (7/03)
S-831	Permit Appeal Process (6/93)
B-833	BLS Ground Ambulance Vehicle Requirements (7/03)
S-835	Requirements for Ground Critical Care Transport Services (7/02)
S-836	Critical Care Transport Unit Inventory (7/02)
N-840	Non Emergency Transport Provider's Permit Application Process (7/03)
N-841	Non Emergency Medical Transport Service Requirements (7/03)
B-850	Basic Life Support Ambulance Service Provider Requirements (1/95)
A-875	Aeromedical Classification (9/91)
A-876	Aeromedical Dispatch Center Designation (9/91)
A-877	Aeromedical Service Provider Authorization (9/91)
A-878	Air Medical Dispatch-Primary Response Rotorcraft (5/97)

Current policy number

(REV – Revised)


**County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services
Master Policy List (7/03)**

SUBJECT: MANAGEMENT OF CONTROLLED DRUGS
ADVANCED LIFE SUPPORT UNITS

Date: 07/01/03

- I. Authority:** California State Board of Pharmacy Business and Professions Code, Section 4019, 4021, California Code of Regulations, Title 22, Division 5, Chapter 5, Section 70001, and D.E.A. 21 Code of Federal Regulations 1301.28.
- II. Purpose:** To ensure accountability for all controlled drugs and devices issued to advanced life support (ALS) units.
- III. Policy:** It is the policy of the County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services that each ALS unit be assigned to one specific Base Hospital for the purpose of initial stocking and resupplying of controlled drugs. Agencies which have a physician in the role of Medical Director may opt to purchase controlled drugs with Form 222 from a pharmacy, or pharmaceutical supply agency, thereby retaining ownership, accountability and responsibility of those controlled drugs.
- IV. Definitions:**
- Controlled Drug:** Pharmaceutical drugs categorized as Category II, III or IV by the Federal Food & Drug Administration.
- V. Procedure:**
- A. Initial Stocking of Unit:
1. Controlled drugs will be issued by the Base Hospital Pharmacy or purchased by the agency physician Medical Director and assigned to its ALS Units according to Drug Enforcement Agency regulations.
 2. All controlled drugs will be issued in tamper evident containers and must be kept under double lock and key system.
- B. Resupplying of Controlled Drugs to Unit:
1. When a controlled drug is used in the field, resupply shall be provided on a one-to-one basis by the

Approved:


Administration


EMS Medical Director

SUBJECT: MANAGEMENT OF CONTROLLED DRUGS
ADVANCED LIFE SUPPORT UNITS

Date: 07/01/03

Pharmacist of the Receiving Hospital (or designee) or restocked from the purchased agency supply.

- a. Unused drugs must be wasted in the presence of the Emergency Department Registered Nurse and the ALS Personnel.
 - b. The hospital controlled drug record information, including the name of the Physician or MICN ordering the drug, must be completed and signed by both the Registered Nurse and the ALS Personnel. If the controlled drug is given under standing orders or communication failure protocols, the Base Hospital Physician on duty shall be listed on the record.
 - c. A new tamper evident container will be issued to the ALS Personnel.
2. Drugs that have passed the expiration date or incurred breakage or violation of tamper proof packaging must be replaced by the Pharmacist or designee at the Base Hospital or replaced by the agency physician Medical Director. The broken or out-dated drug must be presented to receive a replacement.
 3. Only a currently licensed Paramedic, Physician or Registered Nurse shall sign for replacement drugs. The Paramedic, Physician or R.N. shall show wallet identification card if necessary to verify identity.

C. Controlled Drug Record keeping by ALS Personnel:

1. Each ALS Unit shall maintain a standardized written record of controlled drug inventory. That record shall be available to the Base Hospital Pharmacist (or designee) for routine inspection, and shall be maintained by the agency for a period of three (3) years in compliance with the State Board of Pharmacy.
2. Drugs shall be inventoried by the ALS Personnel at the beginning and at the conclusion of each shift, and documentation shall include the signatures of the person(s) performing the inventory and noted on the controlled drug inventory.

Approved:



Administration



EMS Medical Director

**SUBJECT: MANAGEMENT OF CONTROLLED DRUGS
ADVANCED LIFE SUPPORT UNITS**


Date: 07/01/03

3. Any time a controlled drug is administered, the name of the drug, the dose administered, the date of administration, the amount wasted, the patient name, the name of the licensed person administering the medication, the receiving facility and the Q.A. Net run number, if available, shall be documented on the controlled drug inventory.
4. If any medication has been wasted, both the emergency department Registered Nurse and the ALS personnel must sign the controlled drug inventory.
5. Any discrepancy between the written ALS Unit controlled drug inventory and the count of on board drugs shall be noted on the controlled drug inventory sheet and shall be signed by the ALS Team first noting the discrepancy. That discrepancy shall be verbally reported to the assigned Base Hospital Pharmacist (or designee) immediately, followed by written report to the Base Hospital Pharmacist and the Division of Emergency Medical Services within 24 hours.

D. Controlled Drug Inspection/Audit of ALS Units:

1. Periodic unannounced inspections or audits of controlled drugs and/or controlled drug inventory shall be conducted no less than four times each year.
2. The ultimate authority for supervision of controlled drugs lies with the Supervising Inspector of the State Board of Pharmacy. The Supervising Inspector of the State Board of Pharmacy may designate a Deputy Inspector, or a pharmacist located in San Diego County. With the permission of the Supervising Inspector of the State Board of Pharmacy, the pharmacist of the Base Hospital (Pharmacy) may conduct such inspections.
3. The EMS Medical Director or designee may perform announced or unannounced periodic inspections to document compliance with this policy at any time.

Approved:


Administration


EMS Medical Director

SUBJECT: Scope of Practice of EMT-Paramedic in San Diego County

Date: 7/1/00

I. Authority: Health and Safety Code, Division 2.5, Sections 1797.172 and 1798.

II. Purpose: To identify the scope of practice of EMT-Paramedics in San Diego County.

III. Policy:

- A. An EMT-Paramedic (EMT-P) may perform any activity identified in the scope of practice of an EMT-I in Chapter 2 of the California Code of Regulations, Division 9, Title 22.
- B. An EMT-P student, or a currently certified EMT-P affiliated with an approved EMT-P service provider, while caring for patients in a hospital as part of his/her training or continuing education, under the direct supervision of a physician, registered nurse, or physician's assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may, in accordance with the County of San Diego Division of Emergency Medical Services Policies, Procedures and Protocols, perform the following procedures and administer the following medications:
 - 1. Perform defibrillation.
 - 2. Perform synchronized cardioversion.
 - 3. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with forceps.
 - 4. Perform pulmonary ventilation by use of the lower airway multi-lumen adjuncts (esophageal tracheal airway device [ETAD or Combitube®]), and by oral endotracheal intubation (adult and pediatric*).
 - 5. Institute intravenous (IV) catheters, needles or other cannulae (IV lines) in peripheral veins, institute saline locks, and monitor and administer medications through pre-existing vascular access.
 - 6. Administer intravenous glucose solutions or isotonic salt solutions.
 - 7. Obtain venous and capillary* blood samples.
 - 8. Use pneumatic antishock trousers*.
 - 9. Perform Valsalva's maneuver and carotid sinus massage*.
 - 10. Perform nasogastric intubation* and gastric suction*.
 - 11. Perform needle thoracostomy.

Approved:



Administration



EMS Medical Director

SUBJECT: Scope of Practice of EMT-Paramedic in San Diego County

Date: 7/1/00

12. Monitor thoracostomy tubes.
13. Monitor and adjust IV solutions containing Potassium equal to or less than 20mEq/L.
14. Perform blood glucose monitoring test.*
15. Administer, using prepackaged products when available, the following medications:
 - a. 25% and 50% dextrose;
 - b. activated charcoal;
 - c. adenosine;
 - d. albuterol;
 - e. aspirin;
 - f. atropine sulfate;
 - g. atrovent (ipratropium bromide);*
 - h. bretylium tosylate;
 - i. calcium chloride;
 - j. diphenhydramine;
 - k. dopamine hydrochloride;
 - l. epinephrine;
 - m. furosemide;
 - n. glucagon;
 - o. lidocaine hydrochloride;
 - p. midazolam;
 - q. morphine sulfate;
 - r. naloxone hydrochloride;
 - s. oxytocin;*
 - t. sodium bicarbonate;

Approved:



Administration



EMS Medical Director

SUBJECT: Scope of Practice of EMT-Paramedic in San Diego County

Date: 7/1/00

- u. nitroglycerine preparations (excluding IV);
- v. verapamil.*

- w. 2-PAM Cl (pralidoxime chloride)* *-only for paramedics who have received specialized Metropolitan Medical Strike Team training and are working on specially designated response units.*

(Note: Items identified with an asterisk are included as a local optional paramedic intervention, pursuant to CCR Title 22, Div 9, Sec 100145,c,2)*

16. Perform any prehospital emergency medical care treatment procedure(s) or administer any medication(s) on a trial basis when approved by the medical director of the local EMS agency. Study procedure shall be as defined in Title 22, Division 9, Chapter 4 of the California Code of Regulations.
17. Previously established treatment modalities which are encountered upon paramedic arrival, shall be left in place unless directed to discontinue or remove by Base Hospital Physician order (see Policy S-135).

Approved: _____



Administration



EMS Medical Director

SUBJECT: PREHOSPITAL DETERMINATION OF DEATH

Date: 07/01/03

I. Authority: Health and Safety Code, Division 2.5, Section 1798.

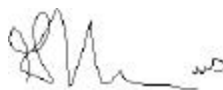
II. Procedure:

- A. When the patient is determined to be "obviously dead", resuscitation measures shall not be initiated.
1. The "obviously dead" are victims who, in addition to absence of respiration and cardiac activity, have suffered one or more of the following:
 - Decapitation
 - Evisceration of heart or brain
 - Incineration
 - Rigor Mortis
 - Decomposition
 2. The EMT shall describe the incident and victim's condition on the Prehospital Patient Record clearly stating the reasons that life support measures were not initiated.
- B. All patients with absent vital signs who are not "obviously dead" shall be treated with resuscitative measures. Base Hospital Physician may make pronouncement of death by radio communication.
- C. In multi-patient incidents, where staffing resources are limited, CPR need not be initiated for arrest victims, however, if CPR has been initiated prior to the arrival of ALS personnel or briefly during assessment, discontinue only if one of the following occurs or is present:
- 1) subsequent recognition of obvious death
 - 2) per BHPO
 - 3) presence of valid DNR Form/Order, Medallion/Advanced Health Care Directive
 - 4) lack of response to brief efforts in the presence of any other potentially salvageable patient requiring intervention.
- D. Except for signs of obvious death, if CPR has been initiated, BLS should be continued while contact is established with the Base Hospital.
1. Once the patient has been pronounced by the Base Hospital Physician, the EMT shall discontinue resuscitative efforts and she/he may contact the Medical Examiner.

Approved:



Administration



EMS Medical Director

SUBJECT: PREHOSPITAL DETERMINATION OF DEATH

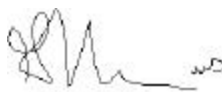
Date: 07/01/03

-
2. The EMT shall describe the incident and the patient's condition on the Prehospital Patient Record, clearly stating the circumstances under which resuscitative efforts were terminated, to include the name of the Base Hospital Physician who pronounced the patient, and all available EKG monitoring documentation.
 3. Patients undergoing transport in CPR status may be pronounced in route by a Base Hospital Physician Order (BHPO). Criteria to pronounce may include:
 - a. medical futility;
 - b. latent discovery of a valid DNR;
 - c. development of obvious signs of death;
 - d. social concerns on scene such as large gatherings, unattended children, highly visible public settings, sensitive family contacts or crew safety or inclement weather, which may require transport of a patient who would otherwise be pronounced on scene.
 4. Disposition of patients pronounced in an ambulance:
 - a. Deliver the deceased to the closest appropriate BEF and have the deceased logged in as an E.D. patient.
 - b. Turn over will be given to the BEF staff. The Prehospital Patient Record (PRP) and all personal belongings will be left with the deceased.
 - c. The receiving facility will assume responsibility for the deceased and contact the coroner, OTAC, morgue, and provide any necessary social services for the family.
- E. For patients with written, signed "Do Not Resuscitate" orders, follow procedures as established in San Diego County Division of EMS Policy S-414.

Approved:



Administration



EMS Medical Director

SUBJECT: Physician on Scene

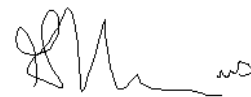
Date: 07/01/02

- I. Authority:** Health and Safety Code, Division 2.5, Sections 1798 and 1798.6.
- II. Purpose:** To establish a mechanism for prehospital patient care when a Physician-on-Scene offers assistance to the Paramedic.
- III. Policy:**
The Paramedic may only follow orders from a Base Hospital Physician or authorized RN (MICN).
- IV. Procedure:**
- A. Paramedics to facilitate immediate consultation with Base Hospital Physician by providing radio or phone contact.
 - B. Base Hospital Physician shall relay information of Attachment A to Physician-on-Scene.
 - C. If Physician-on-Scene chooses to take total responsibility for the patient.
 - 1. Base Hospital Physician may request proof of State of California licensure to be shown to paramedics.
 - 2. Base Hospital Physician must approve or deny a Physician-on-Scene's request to take total responsibility for patient.
 - 3. The Paramedic may assist the Physician-on-Scene with EMT Basic level skills.
 - 4. Drugs and equipment may be made available for the Physician-on-Scene's use.
 - D. Paramedic/MICN shall document Physician-on-Scene's name and on scene involvement on the patient care record.

Approved:



Administrator



Medical Director

ATTACHMENT A

NOTE TO PHYSICIAN ON INVOLVEMENT WITH EMT-PARAMEDICS

An ALS support team (EMT-Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under the authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If s/he wants to assist, this can only be done through one of the alternatives listed. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code" (see Business and Professions Code, Sections 2144, 2395-2398 and Health and Safety Code, Section 1799.104).

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself to the paramedic by name as a physician licensed in the State of California, and consulting with the Base Hospital physician and, if requested, showing proof of identity, you may choose to do one of the following:

1. Offer your assistance with another pair of eyes, hands, or suggestions, but let the life support team remain under base hospital control; or,
2. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. (Whenever possible, remain in contact with the base station physician.)

The California Health and Safety Code, Division 2.5, Chapter 5, Section 1798.6 (a) states as follows:

Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

A key phrase in this is "...who is most medically qualified specific to the provision of rendering emergency care." The most medically qualified person certainly ought to be the base hospital physician, who is familiar with the county EMS system and paramedic procedures and protocols, and consequently, by extension, the base hospital nurse on the radio. The paramedic on scene is viewed as an extension of the base hospital physician, acting as his eyes and ears, and functions under his directions and orders.

Almost always, physicians on scene would be less qualified **specific to the provision of rendering emergency care**, and the paramedic/base hospital nurse/base hospital physician would be legally in charge of the scene.

It is certainly in everyone's best interest to have a smoothly operating team at the scene, and it is imperative that any physician on scene, expressing in whatever manner that he wants to be in command medically, be immediately put in radio contact with the base hospital physician.

ATTACHMENT I (continued)

The following is some suggested dialogue for the base hospital physician...

"Doctor, my name is I am the base hospital physician atHospital and we are in medical control of the paramedic unit at your scene.

"Generally, the medics can most efficiently get the patient under treatment and into the emergency care system under our radio direction, and if that is alright with you, I can give them that direction by radio. Would that be alright with you?"

"If so, let me speak to the medics on the radio and I will get things under way with them. Perhaps, if you wish, you could stand by to lend an extra pair of eyes and hands but remember that the paramedics are closely limited by state law and county policies on what specific procedures they can do, and state law allows them to take orders only from the base hospital.

IF THE PHYSICIAN INSISTS ON TAKING MEDICAL CONTROL

"Doctor, I understand that you wish to take total responsibility for the care given by the life support team. To do so, requires that you are licensed in the state of California and can show your license to the medics on scene. You must also accompany the patient until he arrives at the hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. Is that your wish and intention?"

"If so, I would ask that you state your name for the radio record and show the paramedics your California license. Could you also briefly tell me if you are on the staff of any local hospitals and what your training or specialty is, particularly with reference to the care of this patient.

"Please be advised again, that the state law does not allow the paramedics to take orders from anyone other than the base hospital physician, but they can assist you with basic life support.

...(It is the base hospital physician's option to make the equipment and drugs available to the on scene physician if he approves of his scene control.)

"Doctor, based on the information you have given me on the radio record, I am turning over medical control of the scene to you. You may request medications and drugs from the paramedics and they will assist you with basic life support. I will be standing by on the radio in case a problem arises and you need to discuss something further with me. If you would put the medics back on the radio, I will so advise them. Thank you.

....

If you cannot establish the competence of the on scene physician to your satisfaction, you should not turn over medical control. You may reference the previous information in a manner such as...

"California Health and Safety Code section 1798.6 specifically states that authority for patient health care management in an emergency shall be vested in that licensed ... professional...who is most medically qualified specific to the provision of rendering emergency medical care. In this case, while I want to thank you for your offer of assistance, I'm afraid I do not feel that I can reasonably turn over the scene management to you and I must request that you allow the paramedics to proceed with the emergency care of the patient. If you wish to discuss this with me or my base hospital medical director, Dr, you may phone us later at our hospital at phone number Could you please put the medics back on the radio so I may give them the orders necessary for the patient's care. Again, we would appreciate any cooperation you could give the medics.

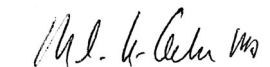
SUBJECT: COMMUNICATIONS FAILURE

Date: 07/01/02

- I. **Authority:** Health and Safety Code, Division 2.5, Section 1797.8 and 1798.2.
- II. **Purpose:** To document the procedure for EMT-paramedic activity during and reporting of communications failure.
- III. **Policy:**
- A. In the event that an EMT-paramedic at the scene of an emergency attempts direct voice contact with a physician or mobile intensive care nurse (MICN) but cannot establish or maintain that contact and reasonably determines that a delay in treatment may jeopardize the patient, the EMT-paramedic may initiate any EMT-paramedic activity authorized by the EMS Medical Director in accordance with the County of San Diego Treatment Protocols, "Standing Orders for Communications Failure", until such direct communication may be established and maintained or until the patient is brought to a general acute care hospital. Direct voice communication with the base hospital shall be attempted at the scene or en route.
- B. In each instance where advanced life support procedures are initiated in accordance with Section A of this Policy, immediately upon ability to make voice contact, the EMT-paramedic who has initiated such procedures shall make a verbal report to the contacted EMT-paramedic Base Hospital Physician or MICN. A "Report of ALS Services Provided Without Base Hospital Contact" form (Attachment A) shall be completed and filed with the contacted EMT-paramedic Base Hospital Physician, when possible, immediately upon delivery of the patient to a hospital, but in no case shall the filing of such documentation be delayed more than twenty-four (24) hours. If no contact is made, the form is filed with the assigned Base Hospital. The Base Hospital Physician shall evaluate this report and forward the report to the EMS Medical Director within seventy-two (72) hours of receipt of report from Paramedic(s).

Approved:


Administration


EMS Medical Director

COUNTY OF SAN DIEGO OFFICE OF EMERGENCY MEDICAL SERVICES

ATTACHMENT A

Report of ALS Services Provided without Base Hospital Contact: In accordance with Health & Safety Code, Division 2.5 Section 1798.4, any incident wherein advanced life support was rendered in the absence of direct communication with a Base Hospital must be verbally reported to the Base Hospital Physician or MICN immediately upon ability to make voice contact, and the following report must be completed; if more than one patient was treated, a separate form must be completed for each patient. Complete reports must be submitted to a Base Hospital Physician at the hospital to which you are regularly assigned within twenty-four (24) hours of the incident.

Date of incident: _____ PM Agency: _____ Unit: _____

Paramedics - (Patient Care): _____ (Radio): _____

Base Hospital (if contact made): _____ Run Number: _____

Assigned Base Hospital: _____ EMS Form Number: _____ (Copy must be attached)

Completely describe the nature of the communication problem including suspected cause, exact geographic location, remedial actions taken, alternate modes attempted:

Detail the conditions and patient assessment that led you to believe the patient was in jeopardy of losing his/her life without ALS Treatment:

What specific ALS treatment was given without medical control?

_What was the patient's condition on arrival at the hospital?

List witnesses at scene (first responders, other medical personnel)

Receiving RN Name: _____

MD Name: _____

Hospital receiving patient:

Incident Reported	Date:	Time:	Agency:	Person reported to:
Verbal report(s)				
Written report:				

We, the above paramedics affirm that the statements made on the report are complete and true to the best of our knowledge.

Signature: _____ Cert #: _____ Date: _____

Signature: _____ Cert #: _____ Date: _____

Written report received by:(signature) _____

Date & Time received: _____ Base Hospital: _____

Base Hospital Physician Review:

Signature: _____, M.D. Date: _____

Please attach copies of the following when submitting this report to the Division of Emergency Medical Services.

- A. All documentation provided by service provider agency and paramedics
- B. Copy of the MICN report form and copy of paramedic tape (if contact was made).
- C. Copy of EMS Prehospital Patient Record

Forward copies of all documentation with 72 hours to:

EMS Medical Director, County of San Diego
Division of Emergency Medical Services
6255 Mission Gorge Road
San Diego, CA 92120

COUNTY OF SAN DIEGO EMERGENCY MEDICAL SERVICES

For Office Use Only

Date and time report received:

Date: _____ Time: _____

Report received by: _____

☐ EMS Medical Director

☐ EMS Chief

☐ EMS Paramedic Coordinator

Reviewer's Comments: _____

Recommended Action:

A. Receive and file - no further action required ☐

B. Forward summary of communication problems to County Communications for review and recommendations ☐

C. Return to Base Hospital for further information ☐ Detail:

D. Return to Base Hospital for the following recommended action(s): ☐

E. Forward to service provider agency for review ☐

F. Other: ☐

Signature of Reviewer: _____

Date: _____ Title: _____

Medical Director Review: _____

Recommended action(s): _____

EMS Medical Director _____ Date: _____

The Office of EMS will review and distribute its findings to the appropriate individuals listed below within thirty (30) days of receipt of this report.

Distribution File

- () () Special Incident
- () () EMT-Paramedic - Name: _____
- () () EMT-Paramedic - Name: _____
- () () Base Hospital - Name: _____
- () () Receiving Hospital - Name: _____
- () () ~~Swing Shift Agency~~
- () () Other: _____

SUBJECT: DETERMINATION OF DEATH

Date: 07/01/02

I. Authority: Health and Safety Code, Division 2.5, Section 1798.

II. Procedure:

A. When the patient is determined to be “obviously dead,” resuscitation shall not be initiated per Policy S-402.

1. The “obviously dead” are victims who, in addition to absence of respirations and cardiac activity, have suffered one or more of the following:

- a. Decapitation
- b. Evisceration of heart or brain
- c. Incineration
- d. Rigor Mortis
- e. Decomposition

2. The prehospital personnel shall describe the incident and victim’s condition on the Prehospital Patient Record, clearly stating the reasons that life support measures were not initiated.

B. It is not the responsibility of aeromedical prehospital personnel to pronounce the death of a patient in the prehospital care setting. However, there may be situations where the flight nurse is called upon to determine death on scene.

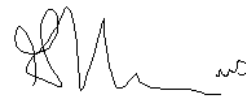
1. If despite resuscitation efforts, the patient remains pulseless and apneic, for the following type of chief complaint or mechanism of injury, the flight nurse may determine death on scene:

- a. Medical CPR
- b. Traumatic CPR
 - 1) Blunt Injury
 - 2) Penetrating Injury

Approved:



Administrator



EMS Medical Director

SUBJECT: DETERMINATION OF DEATH

Date: 07/01/02

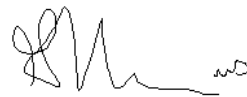
2. Special Considerations:

- a. In cases of obvious death, a monitor need not be used to determine death.
 - b. If a monitor is used, a patient with a rhythm of ventricular fibrillation requires a Base Hospital Physician Order for determination of death.
 - c. If victims of hypothermia, electrocution, lightning strikes and drowning do not meet "obvious death" criteria, determination of death requires a Base Hospital Physician Order.
 - d. In any situation where there may be doubt as to the clinical findings of the patient, basic life support (BLS/CPR) must be initiated.
- C. When a "death has been determined," no basic or advanced life support shall be initiated or continued.
1. The flight nurse is authorized to discontinue CPR or advanced life support (ALS) care initiated at the scene.
 2. The appropriate law enforcement agency must be notified.
 3. In situations where no other emergency medical services (EMS) personnel or authorized personnel are available, the flight crew will remain on scene until released by law enforcement.
 4. The flight crew will document on the prehospital patient record and the flight record the patient's name, if known, the criteria for determination of death, the time the death was determined and resuscitative efforts discontinued.

Approved:



Administrator



EMS Medical Director

SUBJECT: Triage To Appropriate Facility

Date: 3/1/93

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.88 and 1798.
- II. **Purpose:** To provide guidelines for transportation of patients by EMT-paramedics.
- III. **Policy:**
- A. Patients will be transported from the scene of the incident to the most accessible and appropriate hospital having a permit for basic or comprehensive emergency medical services staffed, equipped, and prepared to administer care appropriate to the needs of the patient.
 - B. Trauma center candidates who meet trauma triage criteria will be transported to the most appropriate trauma center.
 - C. Transport to other than the most accessible hospital will be ordered if it is in the best interest of the patient, based on the medical judgment of the Base Hospital providing medical direction in accordance with the County of San Diego, Division of Emergency Medical Services, EMT-Paramedic Treatment Protocols.
 - D. If hospital of preference requested by a patient or patient's adult family member is beyond a reasonable distance from the incident scene or is not medically in the best interest of the patient, refer to Policy P-412 "Release of Medical Responsibility and Alternate Disposition of Patients by EMT-Paramedic".
 - E. Patient medical information will be provided to the receiving hospital emergency department by the Base Hospital at the time the decision is made to transport a patient to that receiving hospital.
 - F. An EMT-Paramedic accompanying patient(s) to a receiving hospital will remain with the patient(s) until medical management is assumed by the receiving hospital's medical staff and will provide such staff with a verbal report and a completed Emergency Medical Services Prehospital Patient Record with all available field cardiac rhythm strips performed.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

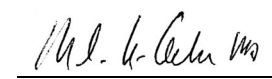
SUBJECT: VARIATION FROM SAN DIEGO COUNTY PROTOCOLS FOR
ADVANCED LIFE SUPPORT (ALS)

Date: 07/01/02

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- I. **Authority:** Health and Safety Code, Sections 1797.90, 1797.202, 1797.220, 1798 (et.seq.)
- II. **Purpose:** To identify the process by which a Base Hospital Physician may issue medical orders that vary from standard San Diego County ALS protocols.
- III. **Policy:**
- A. Base Hospital Physicians may issue medical treatment orders which vary from San Diego County ALS treatment protocols under the following criteria:
 - 1. The order must be within the California Scope of Practice for EMT-Paramedics (Title 22, Section 100144), or within the San Diego County expanded Scope of Practice for EMT-Paramedics (SD County policy P-401).
 - 2. The order must be transmitted to field personnel by the Base Hospital Physician or authorized mobile intensive care nurse (MICN) via direct voice contact.
 - 3. Variation from protocol must be deemed necessary by the Base Hospital Physician to prevent serious morbidity or mortality.
 - B. The EMT-Paramedic (EMT-P) nor and/or the MICN will shall not be subject to disciplinary actions for carrying out or declining orders that vary from protocol that meet the above criteria.
 - C. All variations from protocol shall be reported to the EMS Medical Director and the Prehospital Audit Committee for evaluation and tracking.
- IV. **Procedure:**
- A. The Base Hospital Physician, after determining that a variation from protocol (a "Variation") is necessary to prevent serious morbidity or mortality, shall:
 - 1. transmit the order personally to the field personnel or instruct the MICN to transmit the order via direct voice communication, and

Approved:


Administration


EMS Medical Director

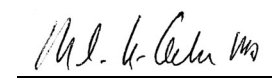
**SUBJECT: VARIATION FROM SAN DIEGO COUNTY PROTOCOLS FOR
ADVANCED LIFE SUPPORT (ALS)**

Date: 07/01/02

2. sign the MICN run sheet or otherwise document the order, and
 3. complete "Notification of Variation from Advanced Life Support Treatment Protocol" (Attachment A) and submit it to the Base Hospital Medical Director, Base Hospital Nurse Coordinator or designee within twenty-four 24 hours of the occurrence of the incident.
- B. The MICN shall:
1. receive the verbal order with explanation of rationale from the Base Hospital Physician and acknowledge that the order is a Variation from ALS protocol, and
 2. transmit the order to field personnel (if the physician has not already done so), and state that "this Variation from ALS protocol was ordered by Dr. _____ ", and
 3. obtain the physician's signature or otherwise document the source of the order, and
 4. initiate a Notification of Variation from ALS Treatment Protocol form for the Base Hospital Physician to complete.
- C. The EMT-Paramedic shall:
1. receive the order with explanation of rationale if needed directly from the Base Hospital Physician or MICN via direct voice communication, and
 2. acknowledge that the order received is a variation from San Diego County ALS protocol, and the Base Hospital Physician who gave the order and
 3. document on EMS Prehospital Patient Record the order for the Variation, and the name of the Base Hospital Physician (and the name of the MICN transmitting the order, if applicable) ordering the Variation.
- D. The Base Hospital Medical Director or Base Hospital Nurse Coordinator shall gather all pertinent data relevant to the incident. This information will be documented on, or with, the Notification form.

Approved:


Administration


EMS Medical Director

**SUBJECT: VARIATION FROM SAN DIEGO COUNTY PROTOCOLS FOR
ADVANCED LIFE SUPPORT (ALS)**

Date: 07/01/02

- E. The Base Hospital Medical Director shall review the Variation to determine if it was necessary to prevent serious morbidity or mortality, and was consistent with San Diego County Scope of Practice for EMT-Paramedics or the State of California EMT-P Scope of Practice. The Base Hospital Medical Director shall document this determination, and any necessary educational efforts with the field, medical physician or nursing personnel involved, on the Notification form, and cause a copy of this form (and attachments) to be submitted to the San Diego County Division of EMS Medical Director for review and analysis (including review for the Prehospital Audit Committee).

Approved:


Administration


EMS Medical Director

COUNTY OF SAN DIEGO
PREHOSPITAL QUALITY ASSURANCE REPORT - *Confidential*

**NOTIFICATION OF VARIATION FROM SAN DIEGO COUNTY ADVANCED LIFE
SUPPORT TREATMENT PROTOCOL**

Reporting Base Hospital:

Date & Time of Incident:

MICN: Run #: Unit Agency and #:

Field Personnel (EMT-P's or EMT-I's):

Base Hospital Physician:

Specific Physician Order:

Description of Incident:

Base Hospital Physician Comments:

Base Hospital Medical Director review, action and comments:

- ☐ This variation is deemed necessary to prevent serious morbidity or mortality
☐ This variation was within the California/SD County EMT-P Scope of Practice
Comment:

Base Hospital Medical Director date Base Hospital Nurse Coordinator date
***** **FOR COUNTY USE ONLY** *****

County EMS Medical Director Comment:

Action:

[] Received EMS date _____ [] PAC Report date _____


SUBJECT: **REPORTING OF ISSUES IN PATIENT CARE MANAGEMENT**

Date: 07/01/03

- I. Authority:** Health and Safety Code, Division 2.5, Section 1797.220 and 1798.102.
- II. Purpose:** To establish the policy for reporting issues in patient care management in the prehospital care system to the San Diego County Emergency Medical Services Medical Director. The goal of this policy is to protect patients from harm and relies upon cooperation from all members of the prehospital care system.
- III. Policy:**
- A. The Base Hospital Medical Director, or designee, will promptly report issues in patient care management to the County of San Diego Emergency Medical Services Medical Director, including, but not limited to:
1. Actions outside the scope of practice of certified Emergency Medical Services personnel.
 2. Major medication errors.
 3. Repeated and unresolved incidents.
 4. Major airway complications.
- B. The Base Hospital will implement its own policies and procedures for providing an organized evaluation of the advanced life support system within the Base Hospital's area of responsibility.

Approved:


Administration


EMS Medical Director

**SUBJECT: SAN DIEGO COUNTY SPECIAL ASSIGNMENT -
EMT-PARAMEDIC**

Date: 07/01/02

- I. Authority:** Health and Safety Code, Division 2.5, Sections 1797.172 and 1798.4, Title 22, Section 100141.
- II. Purpose:** To establish policy for special paramedic operations and patient care while assigned to extraordinary special assignments or missions.
- III. Policy:**
- A. This policy applies only to those currently certified EMT-Paramedics formally appointed and assigned by an approved EMT-P service provider agency which has been designated by the County of San Diego, Division of Emergency Medical Services (EMS) to provide personnel for special assignments or missions exclusively at the request of security/law enforcement/other services approved by the EMS Medical Director.
 - B. This policy is operative only for the duration of a specific special assignment or mission of the agencies specified in "A" above.
 - C. EMT-Paramedics on special assignment will not be required to make Base Hospital contact to treat patients due to the operational requirements of the special assignment/mission that prohibit the practical employment or presence of telemetry communications equipment.
 - 1. The EMT-Paramedics will experience communications failure by default due to the nature of a special assignment/mission.
 - 2. EMT-Paramedics shall establish base hospital radio contact at the earliest opportunity afforded by the circumstances of the special assignment/mission should it become necessary to engage in ALS level treatment.
 - D. EMT-Paramedics engaged in a special assignment or mission may, as the mission dictates, treat patients in accordance with the following:
 - 1. EMT-Paramedic Treatment Protocol P-100 ALS Standing Orders.
 - 2. EMT-Paramedic Treatment Protocol P-133 Standing Orders for Communications Failure.

Approved:



Administration



EMS Medical Director

**SUBJECT: SAN DIEGO COUNTY SPECIAL ASSIGNMENT -
EMT-PARAMEDIC**

Date: 07/01/02

3. A report must be filed as specified in Protocol P-133 Attachment "A" should any patient receive ALS treatment in connection with a special assignment/mission when communication failure occurs.
- E. EMT-Paramedic engaged in a special assignment/mission will be permitted to operate and engage in patient care without a second EMT-Paramedic partner or authorized Mobile Intensive Care Unit (MICU) as the logistics of the special assignment/mission dictate.
- F. EMT-Paramedics are responsible to maintain sufficient equipment and medical supplies necessary to treat a victim that meets the requirements of this special assignment protocol.
- G. The transport of victim(s) to receiving hospitals shall at all times be consistent with existing state and county policy except as security and other considerations require with respect to special assignments for the U.S. Secret Service and U.S. State Department exclusively.

Approved:



Administration



EMS Medical Director

SUBJECT: REPORTING OF SUSPECTED CHILD, DEPENDENT ADULT, OR
ELDER ABUSE/NEGLECT

Date: 7/1/01

-
- I. **Authority:** Health and Safety Code, Division 2.5, Section 1798 and; Child Abuse: California Penal Code, Article 2.5; and, Elder Abuse: Chapter 1273, Statutes of 1983, SB 1210, Sections 9381(a) and 9382, Welfare and Institutions Code Chapter II, Part 3, Division 9.
- II. **Purpose:** To establish a policy for identification and reporting of incidents of suspected child, dependent adult or elder abuse/neglect.
- III. **Policy:** All San Diego County prehospital care personnel are required to report incidents of suspected neglect of, or abusive behavior toward children, dependent adults or elders.
- IV. **Reporting Procedure:**
- A. Child Abuse/Neglect:
1. Suspicion of Child Abuse/Neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline [(858) 560-2191] immediately or as soon as possible. Be prepared to give the following information:
 - a. name of person making report;
 - b. name of child;
 - c. present location of the child;
 - d. nature and extent of the abuse/neglect;
 - e. information that led reporting person to suspect child abuse/neglect;
 - f. location where incident occurred, if known; and
 - g. other information as requested.
 2. Phone report must be followed within thirty-six (36) hours by a written report on "Suspected Child Abuse Report" form #SS8572 (see attached). The mailing address for this report is: Health and Human Services Agency (HHSA), Children's Services

Approved:



Administration



EMS Medical Director

SUBJECT: REPORTING OF SUSPECTED CHILD, DEPENDENT ADULT, OR
ELDER ABUSE/NEGLECT

Date: 7/1/01

Child Abuse Hotline, 6950 Levant Street, San Diego, CA 92111. Fax of this report is not authorized.

3. The identity of all persons who report under this article shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protective agency, or to the district attorney in a criminal prosecution or by court order.

B. Dependent Adult and Elder Abuse/Neglect:

1. Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by telephone to the Adult Protective Services at HHSA Aging and Independent Services (800-510-2020). Be prepared to give the following information:
 - a. name of person making report;
 - b. name, address, and age of the dependent adult or elder;
 - c. nature and extent of person's condition; and,
 - d. other information, including information that led the person to suspect abuse/neglect.
2. Telephone report must be followed by a written report within forty-eight (48) hours of the telephone report using "Report of Suspected Dependent Adult/Elder Abuse" form SOC 341 (see attached). The mailing address for this report is: Adult Protective Services, 9335 Hazard Way #100, San Diego, CA 92123. The report may be faxed to (858) 694-2568.
3. The identify of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.

Approved:



Administration



EMS Medical Director

SUBJECT: REPORTING OF SUSPECTED CHILD, DEPENDENT ADULT, OR
ELDER ABUSE/NEGLECT

Date: 7/1/01

-
- C. When two or more persons who are required to report are present at scene, and jointly have knowledge of a suspected instance of child, dependent adult, or elder abuse/neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make such report.
- D. The reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided they are consistent with the provisions in this article.

Approved:



Administration



EMS Medical Director

**SUBJECT: PREHOSPITAL TREATMENT AND TRANSPORTATION OF ADULTS -
REFUSAL OF CARE OR SUGGESTED DESTINATION, RELEASE**

Date: 07/01/03

- I. Authority:** Health and Safety Code, Division 2.5, Section 1798.
- II. Purpose:** To establish a procedure for a patient or designated decision maker (DDM) to refuse care (assessment, treatment, or transport) or request an alternate disposition by EMS personnel.
- III. Definitions:**
- A. AMA - The refusal of treatment or transport, by an emergency patient or his/her designated decision maker, against the advice of the medical personnel on scene or of the base hospital.
 - B. Designated decision maker (DDM) - An individual to whom a person has legally given the authority to make medical decisions concerning the person's health care (i.e., through a Durable Power of Attorney for Health Care).
 - C. Emergency Patient - Any person for whom the 9-1-1/EMS system has been activated and who meets the following criteria:
 - 1. Has a chief complaint or suspected illness or injury; or
 - 2. Is not oriented to person, place, time, or event; or
 - 3. Requires or requests field treatment or transport; or
 - 4. Is under the age of 18 and is not accompanied by a parent or legal guardian.
 - D. Release - A call outcome that occurs when the patient and the EMS personnel (including the base hospital if a base was contacted) agree that the illness/injury does not require immediate treatment/transport via emergency/9-1-1 services and the patient does not require the services of the prehospital system.
- IV. Policy:**
- A. All emergency patients will be offered treatment and/or transport following a complete assessment.
 - B. Against Medical Advice (AMAs)

Approved:



Administration



EMS Medical Director

**SUBJECT: PREHOSPITAL TREATMENT AND TRANSPORTATION OF ADULTS -
REFUSAL OF CARE OR SUGGESTED DESTINATION, RELEASE**

Date: 07/01/03

1. Adults have the right to accept or refuse any and all prehospital care and transportation, provided that the decision to accept or refuse these treatments and transportation is made on an informed basis and provided that these adults have the mental capacity to make and understand the implications of such a decision.
2. The decisions of a Designated Decision Maker (DDM) shall be treated as though the patient was making these decisions for him/herself.
3. For those emergency patients who meet base hospital contact criteria (S-415) and wish to sign AMA, prehospital personnel shall use their best efforts to make base hospital contact prior to the patient leaving the scene and prior to the responding unit leaving the scene. In the event that the patient leaves the scene prior to base hospital contact, field personnel shall still contact the base hospital for quality improvement and trending purposes only.
4. The EMT-I or paramedic should contact the base hospital and involve the MICN and/or base hospital physician in any situation in which the treatment or transport refusal is deemed life threatening or "high risk" by the EMT-I or paramedic.
5. Field personnel shall document, if possible, the following for all patients released AMA:
 - a. Who activated 9-1-1 and the reason for the call.
 - b. All circumstances pertaining to consent issues during a patient encounter.
 - c. The presence or absence of any impairment of the patient/DDM such as by alcohol or drugs.
 - d. The ability of the patient/DDM to comprehend and demonstrate an understanding of his/her illness or injury.
 - e. The patient/DDM has had the risks and potential outcome of non-treatment or non-transport explained fully by the EMT or Paramedic, such that the patient/DDM can verbalize

Approved:



Administration



EMS Medical Director

**SUBJECT: PREHOSPITAL TREATMENT AND TRANSPORTATION OF ADULTS -
REFUSAL OF CARE OR SUGGESTED DESTINATION, RELEASE**

Date: 07/01/03

understanding of this information.

- f. The reasons for the AMA, the alternate plan, if any, of the patient/DDM and the presence of any on-scene support system (family, neighbor, or friend [state which]).
- g. That the patient/DDM has been informed that they may re-access 9-1-1 if necessary.
- h. The signature of the patient/DDM on the AMA form, or, if the prehospital personnel are unable to have an AMA form signed, the reason why a signed form was not obtained.
- i. Consideration should be given to having patient/family recite information listed in sections IV.B.5. d-g above, to the MICN/BHP over the radio or telephone.

C. Patient Refusal of Transport to Recommended Facility

Should the situation arise wherein a patient refuses transport to what is determined by the base hospital to be the most accessible emergency facility equipped, staffed and prepared to administer care appropriate to the needs of the patient, but the patient requests transport to an alternate facility:

- 1. Field personnel should discuss with the base hospital the patient's or DDM's rationale for their choice of that alternate facility.
- 2. Inform the patient or DDM of base hospital's rationale for its selected destination.
- 3. If the patient still refuses transport to the selected destination, follow procedures for the patient to refuse treatment and/or transport "against medical advice" (AMA). However, if, in the judgment of the base hospital, the patient's refusal of transport would create a life-threatening or high-risk situation, and the patient continues to refuse the recommended destination, document the AMA and transport the patient to the requested facility if possible.
- 4. Arrange for alternate means of transportation to the facility of choice if appropriate.

D. Downgrade

Approved:



Administration



EMS Medical Director

**SUBJECT: PREHOSPITAL TREATMENT AND TRANSPORTATION OF ADULTS -
REFUSAL OF CARE OR SUGGESTED DESTINATION, RELEASE**

Date: 07/01/03

1. Following a complete paramedic assessment and base hospital report (as required per San Diego County EMS Policy S-415), the base hospital may authorize a downgrade in the transportation and treatment needs of an ALS-dispatched patient from advanced life support (i.e., paramedic treatment and transport) level of prehospital care to BLS (EMT-I treatment and transport) level of care and that unit can continue to transport the patient to any destination. All downgrades shall be reviewed by the agency's internal Quality Improvement program.
2. If the patient's condition deteriorates during the transport, the paramedic shall contact the base hospital authorizing the downgrade, initiate appropriate ALS treatment protocols, and deliver the patient to the most appropriate facility at the direction of the base hospital. The Base Hospital shall generate a report to the Prehospital Audit Committee documenting the incident.
3. If the paramedics have transferred care to a BLS service provider and the patient's condition deteriorates during the BLS transport, the EMT-I shall contact a base hospital, inform the base hospital that the patient had been downgraded from ALS to BLS, and deliver the patient to the most appropriate facility at the direction of the base hospital. The Base Hospital shall generate a report to the Prehospital Audit Committee documenting the incident.

E. Release

If the patient and EMS personnel (including the base hospital if a base was contacted) agree that the illness/injury does not require immediate treatment/transport via emergency/9-1-1 services, and the patient does not require the services of the prehospital system, the patient may be released at scene. For those patients who meet base hospital contact criteria (S-415), field personnel shall attempt to contact the base prior to the patient leaving the scene.

Approved:



Administration



EMS Medical Director

SUBJECT: RESUSCITATION

Date: 7/1/01

- I. **Authority:** Health and Safety Code, Division 2.5, Section 1798.
- II. **Purpose:** To establish guidelines for Emergency Medical Technicians (EMT's) (all levels) in San Diego County to determine appropriateness of either:
- A. Discontinuing or withholding resuscitative measures, or;
 - B. Obtaining a Base Hospital Physician Order for pronouncement of patients in cardiac arrest while in the prehospital setting.
- III. **Definition:**
- A. Emergency Medical Technician shall apply to all EMT-I's, EMT/PS-D's, EMT-P's licensed, certified, and/or accredited to function in San Diego County.
 - B. Do not Resuscitate (DNR) means no chest compressions, no defibrillation, no assisted ventilation, no endotracheal intubation, and no cardiotoxic drugs. The patient is to receive full treatment other than resuscitative measures (e.g., for airway obstruction, pain, dyspnea, major hemorrhage, etc.).
 - C. Absent vital signs: absence of respirations and absence of a carotid pulse.
 - D. DNR Medallion: metal or permanently imprinted insignia, belonging to the patient, that is imprinted with the words "Do Not Resuscitate, EMS."
 - E. DNR Form: Any completed "Do Not Resuscitate Form."
 - F. Advance Health Care Directive: An individual health care instruction or a power of attorney for health care.
- IV. **Procedure:**
- A. All patients with absent vital signs who are not "obviously dead," (refer to Policy S-402) shall be treated with resuscitative measures, unless one of the following circumstances apply:

Approved:



Administration



EMS Medical Director

SUBJECT: RESUSCITATION

Date: 7/1/01

1. An EMT may withhold CPR if presented with one of the following:
 - a. DNR Medallion.
 - b. A completed DNR Form stating, "Do not resuscitate," "No code," or "No CPR."
 - c. A written, signed order in the patient's medical record.
 - d. An Advance Health Care Directive.
 - e. Upon receipt of a Base Hospital Physician Order.

2. An EMT may discontinue CPR if presented with one of the following:
 - a. A DNR Medallion.
 - b. A completed DNR Form stating, "Do not resuscitate," "No code," or "No CPR."
 - c. A written, signed order in the patient's medical record.
 - d. An Advance Health Care Directive.
 - e. Upon receipt of a Base Hospital Physician Order.

B. Documentation

Reason for withholding or terminating CPR shall be documented in the patient care record. DNR orders shall include the name of the physician or designee (e.g. Physician Assistant, Nurse Practitioner), and the date of the order. If patient transport is initiated, the DNR Form (original or copy), DNR Medallion, or a copy of the valid DNR Order from the patient's medical record shall accompany the patient.

Approved:



Administration



EMS Medical Director

SUBJECT: RESUSCITATION

Date: 7/1/01

C. Considerations

1. In the event any patient expires enroute, the following should be considered:
 - a. Unless specifically requested, the patient should not be returned to a private residence or skilled nursing facility, continue to the destination hospital.
 - b. If between hospitals, return to the originating hospital if time is not excessive. If transport time would be excessive, divert to the closest hospital with a basic emergency facility (BEF).
 - c. In rural areas, transporting agencies can contact the Medical Examiner via station M to arrange for a mutually acceptable rendezvous location where the patient may be taken, so that the transporting unit may return to service.

Approved:



Administration



EMS Medical Director

SUBJECT: BASE HOSPITAL CONTACT, PATIENT TRANSPORTATION
AND REPORT - EMERGENCY PATIENTS

Date: 7/1/01

- I. **Authority:** Health & Safety Code, Division 2.5, Section 1797.88; 1798. Title XXII, Section 100170, Civil Section 25.8.
- II. **Purpose:** To identify conditions under which EMT-Is and paramedics shall, when encountering an emergency patient, contact a base hospital for notification, medical direction, or to give report; or (for EMT-Is) contact a receiving hospital to verify appropriate transport destination and give report.
- III. **Definitions:**
- A. **Aid Unnecessary** - Calls in which the person for whom 9-1-1 was called does not meet the definition of “emergency patient,” and has agreed to make alternate transportation arrangements if necessary.
- B. **Call Canceled** - Calls to which EMS personnel were responding but the response was canceled prior to encountering an emergency patient or potential patient.
- C. **Complete Patient Report** - A problem-oriented verbal communication which includes:
1. Acuity.
 2. Age.
 3. Gender.
 4. Chief complaint(s).
 5. Vital signs (including O₂ saturation when possible).
 6. Pertinent history, allergies, medications.
 7. Pertinent findings of the primary and secondary survey.
 8. Field treatment and response.
 9. Anticipated destination facility.
 10. Estimated time of arrival.
- D. **Initial Notification** - A brief communication by the field personnel to provide the acuity, age, gender, and chief complaint of the patient to the base hospital to assist in determining appropriate patient destination. This communication is intended to verify resource capability and availability of the facility that will receive the

Approved:



Administration



EMS Medical Director

SUBJECT: BASE HOSPITAL CONTACT, PATIENT TRANSPORTATION
AND REPORT - EMERGENCY PATIENTS

Date: 7/1/01

patient.

- E. Release - A call outcome that occurs when the patient and the EMS personnel (including the base hospital if a base was contacted) agree that the illness/injury does not require immediate treatment/transport via emergency/9-1-1 services and the patient does not require the services of the prehospital system.
- F. Emergency Patient - Any person for whom the 9-1-1/EMS system has been activated and who meets the following criteria:
 - 1. Has a chief complaint or suspected illness or injury; or
 - 2. Is not oriented to person, place, time, or event; or
 - 3. Requires or requests field treatment or transport; or
 - 4. Is a minor who is not accompanied by a parent or legal guardian and is ill or injured or appears to be ill or injured
- G. Elopement - The departure from the scene of a patient, in which the patient has refused to comply with established procedures for refusing care or transportation.
- H. Minor - A person under the age of 18 and who is not emancipated
- I. Designated decision maker (DDM) - An individual to whom a person has legally given the authority to make medical decisions concerning the person's health care (i.e., a parent, legal guardian, an "attorney in fact" through a Durable Power of Attorney for Health Care, or an "agent" through an Advance Health Care Directive).

IV. Policy:

- A. EMT-Is - Hospital contact is required for all patients who are transported to the Emergency Department of a hospital.
 - 1. EMT-Is shall contact the intended facility as soon as possible to verify their destination and to provide a complete patient report.
 - 2. EMT-Is shall call:

Approved:



Administration



EMS Medical Director

SUBJECT: BASE HOSPITAL CONTACT, PATIENT TRANSPORTATION
AND REPORT - EMERGENCY PATIENTS

Date: 7/1/01

- a. A base hospital if they have a question regarding the appropriate treatment or disposition of any patient.
 - b. A designated trauma center for those patients who meet trauma center criteria (T-460).
 - c. UCSD base for those patients meeting Burn Center criteria (S-124).
- B. EMT-Ps - Base hospital contact is required by paramedics in the following situations (except in cases of elopement - see **III. D.**):
1. Any emergency patient transport by paramedics, including transports by paramedic ambulance to a BLS destination following downgrade to BLS.
 2. Any emergency patient treatment involving ALS medications or skills (except EKG monitoring)
 3. Any emergency patient assessment involving abnormal vital signs, or an altered level of consciousness.
 4. Any suspicion that the emergency patient (or designated decision maker [DDM]) is impaired by alcohol or drugs.
 5. The emergency patient/DDM is unable to comprehend or demonstrate an understanding of his/her illness or injury.
 6. The emergency patient meets criteria as a trauma center candidate (T-460).
 7. The emergency patient is > 65 years of age and has experienced an altered/decreased level of consciousness, significant mechanism of injury, or **any** fall.
 8. An emergency patient who is a minor is ill or injured or is suspected to be ill or injured.
 9. Whenever paramedics have a question regarding appropriate treatment or disposition of the patient.
- C. Any other communications between the patient, DDM, family member or care giver and prehospital personnel regarding refusal of care or care that is in variance with San Diego County prehospital treatment protocols or the San Diego County Resuscitation policy (S-414) (such as an Advance Health Care Directive, Living Will, Comfort Care communication, verbal notification from family member or care giver, DPAHC without

Approved:



Administration



EMS Medical Director

**SUBJECT: BASE HOSPITAL CONTACT, PATIENT TRANSPORTATION
AND REPORT - EMERGENCY PATIENTS**

Date: 7/1/01

- attorney-in-fact present, etc.), shall be immediately referred to the base hospital for evaluation. The base hospital shall evaluate this information and determine the plan of treatment and transport for the patient.
- D. Treatment and transport decisions for emergency patients in involuntary or protective custody (i.e., under arrest by law enforcement, placed on a "5150" hold, or serving a prison term) are to be made by the authority under which they are being held.
- E. Paramedics shall contact a base hospital as soon as possible to verify destination. Paramedics will first attempt to call their regularly assigned base hospital unless the emergency patient meets one of the following criteria:
1. Adult Trauma: For all adult emergency patients who appear to meet trauma center candidate criteria in T-460, paramedics shall first attempt to call the trauma base in the catchment area of the incident.
 2. Pediatric Trauma: Paramedics shall first attempt to contact the designated pediatric trauma base for pediatric trauma center candidates (T-460).
 3. Burns: Paramedics shall first attempt to contact the UCSD base for all emergency patients that meet burn center disposition criteria (S-124).
- F. A complete patient report is required as soon as reasonably possible for all emergency patients transported. However, an initial notification may be made to a base hospital prior to the complete patient report without interfering with the paramedic's ability to implement standing orders. Standing orders for medications may not be implemented following the initiation of a complete patient report.
- G. MICNs shall relay patient information received from the patient report to the appropriate receiving facility personnel.
- H. Treatment and/or Transport of a Minor:
1. Treatment or transport of a conscious minor who is ill or injured or suspected to be ill or injured shall be with the verbal consent of the natural parent, legal guardian, or any adult authorized in writing by the legal guardian pursuant to Section 25.8 of the Civil Code (Attachment A).

Approved:



Administration



EMS Medical Director

**SUBJECT: BASE HOSPITAL CONTACT, PATIENT TRANSPORTATION
AND REPORT - EMERGENCY PATIENTS**

Date: 7/1/01

2. Treatment or transport of a conscious minor who is ill or injured or suspected to be ill or injured, where the natural parents, legal guardian, or authorized persons are not present, will be under the direction of the Base Hospital.
 - a. Transport shall be to the most accessible appropriate receiving or specialty care center.
 3. Treatment or transport of a minor who is unconscious or suffering from a life threatening disease, illness, or injury in the absence of a natural parent, legal guardian or authorized person (Attachment A) may be initiated without parental consent.
- I. Base Hospital contact is NOT REQUIRED on individuals who meet the following criteria:
1. Obvious death (S-402).
 2. Discontinuation of CPR with a Prehospital DNR order or DPAHC on scene (S-414).
 4. Release of a minor on scene who is neither ill nor injured, nor suspected to be ill or injured, may be permissible without Base Hospital contact if:
 - a. Parent or legal guardian so requests

OR

 - b. A responsible adult other than parent or legal guardian (i.e. school nurse, law enforcement, or person of similar standing) so requests.
 - c. The field EMT/EMT-P shall document the circumstances and identification of the person accepting responsibility for the minor.
 5. Patients who wish to be released and do not meet base hospital contact criteria.
 6. Dispatched as a BLS call where ALS treatment or intervention is not anticipated nor required.

Approved:



Administration



EMS Medical Director

**SUBJECT: SUPPLY AND RESUPPLY OF DESIGNATED
EMS AGENCIES AND VEHICLES**

Date: 7/1/01

- I. Authority:** California Health and Safety Code, Division 2.5, Chapter 4, Section 1797.202 and California Business and Professions Code, Division 2, Chapter 9, California Pharmacy Law. Section 4000, et seq.
- II. Purpose:** To provide a policy for agencies to procure, store and distribute medical supplies and pharmaceuticals identified in the Inventory.
- III. Definition:** Dangerous Drugs and Devices: Any drug or device unsafe for self-use (e.g. IV solutions and medications carried on the MICU Inventory). Drugs and devices bearing the legend, "Caution, federal law prohibits dispensing without prescriptions" or words of similar import.
- IV. Policy:**
- A. Each agency shall have a mechanism to procure, store and distribute its own medical supplies and pharmaceuticals under the license and supervision of an appropriate physician. An appropriate physician is considered to be one of the following:
1. The Medical Director of the agency.
 2. The County of San Diego, Division of Emergency Medical Services (EMS) Medical Director.
 3. The Medical Director of a contracted base hospital.
- B. Mechanisms of procurement may include the following:
1. Procurement of pharmaceuticals and medical supplies through a legally authorized source such as a pharmaceutical distributor or wholesaler.
 2. Procurement of pharmaceuticals and medical supplies from a hospital that determines it has the legal authority to resell pharmaceuticals and supplies to an agency.
- C. Each agency shall have procedures in place for the procurement, transport, storage and distribution of Dangerous Drugs and Devices.

Approved:



Administration



EMS Medical Director

**SUBJECT: SUPPLY AND RESUPPLY OF DESIGNATED
EMS AGENCIES AND VEHICLES**

Date: 7/1/01

D. If agency requests the County of San Diego, EMS Medical Director to assume responsibility for providing medical authorization for procuring Dangerous Drugs and Devices, these policies shall be reviewed and approved by the County of San Diego, EMS Medical Director and shall include the following:

1. Identification (by title) of individuals responsible for procurement and distribution.
2. A determination of reasonable quantities of supplies and pharmaceuticals that must be maintained to resupply agencies.
3. Maintenance of copies of all drug orders, invoices, and logs associated with Dangerous Drugs and Devices for a minimum of three years.
4. Procedures for completing a monthly inventory of Dangerous Drugs and Devices, which includes:
 - a. Ensuring medications are stored in original packaging.
 - b. Checking medications for expiration dates, rotating supplies for use prior to expiration, and exchanging for current medications.
 - c. Properly disposing of expired medications that cannot be exchanged.
 - d. Distributing to agencies.
 - e. Returning medications to pharmaceutical distributor if notified of a recall.
5. Storage of drugs (other than those carried on a vehicle) that complies with the following:
 - a. Drugs must be stored in a locked cabinet or storage area.
 - b. Drugs may not be stored on the floor. (Storage of drugs on pallets is acceptable.)
 - c. Antiseptics and disinfectants must be stored separately from internal and injectable medications.
 - d. Flammable substances (e.g., alcohol) must be stored in a metal cabinet, in accordance with local fire codes.

Approved:



Administration



EMS Medical Director

**SUBJECT: SUPPLY AND RESUPPLY OF DESIGNATED
EMS AGENCIES AND VEHICLES**

Date: 7/1/01

-
- e. Storage area is maintained within a temperature range that will maintain the integrity, stability and effectiveness of drugs.
 - 6. Agencies shall develop, implement and maintain a quality assurance and improvement program that includes a written plan describing the program objectives, organization, scope, and mechanisms for overseeing the procurement, transport, storage, distribution and administration of Dangerous Drugs and Devices.
 - E. Agencies under the license and supervision of the County of San Diego, EMS Medical Director shall have a written agreement with the County of San Diego, Division of Emergency Medical Services that is specific to the procurement, transport, storage, distribution and administration of Dangerous Drugs and Devices.

Approved:



Administration



EMS Medical Director

SUBJECT: EMERGENCY MEDICAL TECHNICIAN/PUBLIC SAFETY-DEFIBRILLATION
EQUIPMENT

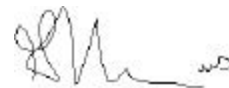
Date: 07/01/03

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.52, 1797.170 and 1797.204.
- II. **Purpose:** To identify specific type of Public Safety-Defibrillation equipment to be used in San Diego County.
- III. **Policy:**
- A. Approved PS-D Programs shall use only automated external defibrillation (AED) equipment capable of generating an event record.
 - B. In areas where PS-D responders have the potential to interface with Advanced Life Support (ALS) units, procedures shall be established which allow for this interface.
 - C. Equipment shall be programmed to comply with current San Diego County treatment protocols.

Approved:



Administration



Medical Director

SUBJECT: TRANSFER OF SPECIFIC PATIENT CARE INFORMATION
BETWEEN FIRST RESPONDERS UTILIZING DEFIBRILLATION
EQUIPMENT AND TRANSPORT PERSONNEL

DATE: 07/01/03

- I. Authority:** Health and Safety Code, Division 2.5, Section 1798 and 1798.6.
- II. Purpose:** To assure effective transfer of patient care information between first responders utilizing defibrillation equipment, and transport personnel at the scene of an emergency.
- III. Policy:** Patient care information shall be communicated between first responders and transport personnel at the time of transfer.
- IV. Procedure:**
- A. Transfer shall be to an equal or higher level of care only.
 - B. Prior to actual transfer of patient care responsibilities, the first responder will provide a verbal report to the transport personnel containing the following information:
 - 1. Patient age.
 - 2. Witnessed/unwitnessed arrest.
 - 3. Approximate time from collapse.
 - 4. Initiation of CPR prior to first responder arrival.
 - 5. Initial monitored rhythm. (shockable vs non-shockable rhythm)
 - 6. Number of defibrillatory shocks delivered and joules of each shock.
 - 7. Response to treatment.
 - B. Once verbal report has been completed, the first responder shall assist the transport personnel in the transfer process as needed.

Approved:



Administration



Medical Director

SUBJECT: APPLICATION OF PATIENT RESTRAINTS

Date: 07/01/02

- I. Authority:** Health & Safety Code, Division 2.5, Section 1798; California Code of Regulations, Title 22, Section 100075, 100159
- II. Purpose:** To establish criteria for the use of restraints in the field or during transport.
- III. Policy:**
- A. When field personnel apply restraints, the safety of the patient, community, and responding personnel shall be of paramount concern.
 - B. Whenever patient restraints have been applied in the field, prehospital personnel shall document in the Prehospital Patient Record the following:
 - 1. The reason the restraints were needed (including previous attempts to control patient prior to restraint use), and;
 - 2. the type of restraint used, the extremity(ies) restrained, the time the restraints were applied, and
 - 3. which agency applied the restraints, and;
 - 4. information and data regarding the monitoring of circulation to the restrained extremities, and;
 - 5. information regarding the monitoring of the patient's respiratory status while restrained.
 - C. Restraints are to be used only for patients who are violent or potentially violent, or who may harm self or others.
 - D. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of a medical condition.
 - E. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise the neurological or circulatory status of the restrained extremity(ies).
 - F. If the patient has been restrained by a law enforcement officer (such as handcuffs, plastic ties, or "hobble" restraints, the following criteria must be met:

Approved:



Administration



EMS Medical Director

SUBJECT: APPLICATION OF PATIENT RESTRAINTS

Date: 07/01/02

1. Restraints must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.
2. Restraints applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer shall accompany the patient in the ambulance. In the unusual event that this is not possible, the officer should follow by driving in tandem with the ambulance on a pre-determined route. Prior to leaving the scene, prehospital personnel shall attempt to discuss an appropriate method to alert the officer of any problems that may develop during the transport requiring the officer's immediate presence.
3. Law enforcement personnel shall attempt, when possible, to modify their restraints to a medically accepted standard prior to transport.

This policy is not intended to negate the use by law enforcement personnel of appropriate restraint equipment that is approved by their respective agencies to establish scene management control.

- G. Restraints or protective devices that have been applied by medical personnel prior to transport may be continued during the transport per instructions from those medical personnel.

IV. Procedure:

- A. Restraint equipment applied by prehospital personnel must be either padded leather restraints or soft restraints (i.e posey, velcro or seatbelt type). The method of restraint must provide for quick release.
- B. The following forms of restraint shall not be used by EMS prehospital care personnel:
1. Any restraint device requiring a key to remove.
 2. Backboard, stretcher or flat used as a "sandwich" restraint.
 3. Devices that restrain a patient's hand(s) and/or feet behind the patient
 4. Methods or materials applied in a manner that could cause vascular or neurological damage to the

Approved:



Administration



EMS Medical Director

SUBJECT: APPLICATION OF PATIENT RESTRAINTS

Date: 07/01/02

patient.

5. Hard plastic ties ("flex-cuffs"). Aeromedical personnel (only) may use hard plastic restraints provided that appropriate provider agency policies regarding the application and monitoring of the extremities restrained, and the use of alternate restraint methods (such as pharmaceutical restraints) are in place.
- C. Patients shall not be restrained in a prone position. Prehospital personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
- D. Restrained extremities shall be evaluated for pulse, movement, sensation and color at least every 15 minutes. The results of each evaluation shall be documented in the Prehospital Patient Record.

Approved:



Administration



EMS Medical Director

SUBJECT: UTILIZATION OF ATROPINE & 2-PAM CL FOR TREATMENT OF
NERVE AGENT EXPOSURE

Date: 7/1/01

- I. Authority:** Health & Safety Code, Division 2.5, Section 1797.105
California Code of Regulations, Title 22, Division 9, Section 100145.2
San Diego County Multicasualty Plan, Annex B & Annex D
- II. Purpose:** To identify the procedure for administration of Atropine and 2-PAMCl (Pralidoxime) for treatment in events of chemical Weapons of Mass Destruction.
- III. Definitions:** Metropolitan Medical Response System (MMRS) - systematic medical response to nuclear, biological or chemical acts of terrorism.
- Metropolitan Medical Strike Team (MMST) - a designated team specially trained and equipped to manage incident scenes of nuclear, biological or chemical acts of terrorism.
- Nerve Agent - a chemical that has biological effects by inhibiting the enzyme acetylcholinesterase, thus allowing the neurotransmitter acetylcholine to accumulate and overstimulate organs and the nervous system causing sudden loss of consciousness, seizures, apnea and death. Nerve agents include Tabun (GA), Sarin (GB), Soman (GD) and VX.
- Terrorism - the unlawful use of force or violence against persons or property or to coerce a government or civilian population in the furtherance of political or social objectives.
- Weapons of Mass Destruction (WMD) - devices specially designed and utilized by terrorists to cause mass illness, injury, death and hysteria on a population.
- IV. Policy**
- A. In a suspected or confirmed event of chemical WMD in response to a release of Nerve Agent when signs and symptoms are exhibited, an Autoinjector or injection device of Atropine and 2PamCl may be administered.
 - B. The primary use of predeployed medication will be for treatment or self-treatment of public safety personnel.
 - C. Atropine and 2-PamCl will be stored and available for use on designated First Responder vehicles, Hazmat Units and deployable cache stockpiles per the MMRS plan.
 - D. Only prehospital personnel who have completed training specific to use of the Atropine and 2-PamCl Autoinjectors are authorized to utilize the MMST Nerve Agent Protocol (S-150).
 - E. If medications are used, MMST must be activated through Incident Commander or Dispatch (if no Incident Commander is present).
 - F. All uses of the medication and activation of the MMRS plan will be reviewed by the MMST Program Management Team with summary reports to the Medical Director and County EMS Prehospital Audit Committee.

Approved:



Administration



EMS Medical Director

SUBJECT: EMERGENCY MEDICAL TECHNICIAN-BASIC
SCOPE OF PRACTICE

Date: 07/01/03

I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170 and 1798, 1797.202 and 1797.214.

II. **Purpose:** To identify the scope of practice of EMT-Basic in San Diego County.

III. **Policy:**

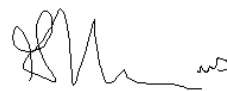
A. During training, while at the scene of an emergency, and during transport of the sick or injured, or during interfacility transfer, a supervised EMT-Basic student or certified EMT-Basic is authorized to do any of the following:

1. Evaluate the ill and injured.
2. Render basic life support, rescue and first aid to patients.
3. Obtain diagnostic signs, including but not limited to temperature, blood pressure, pulse, respiratory rate, level of consciousness, pupil status, and oxygen saturation.
4. Perform cardiopulmonary resuscitation, including the use of mechanical adjuncts to basic cardiopulmonary resuscitation (e.g. use of the automated external defibrillator) (AED).
5. Use the following adjunctive airway breathing aids:
 - a. oropharyngeal airway
 - b. nasopharyngeal airway
 - c. suction devices
 - d. basic oxygen delivery devices, manual and mechanical ventilating devices designed for prehospital use.
 - e. Esophageal Tracheal Airway Device (ETAD) if authorized by the local EMS Medical Director.
6. Use various types of stretchers and body immobilization devices.
7. Provide initial prehospital emergency care for patients with trauma.
8. Administer or assist patient to administer oral glucose or sugar solutions.

Approved:



Administration



Medical Director

SUBJECT: **EMERGENCY MEDICAL TECHNICIAN-BASIC**
SCOPE OF PRACTICE

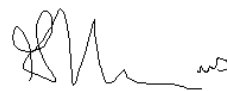
Date: 07/01/03

9. Assist patient to take their own prescribed nitroglycerine.
 10. Extricate entrapped persons.
 11. Perform basic field triage.
 12. Transport patients.
 13. Assist Paramedic to set up for advanced life support procedures excluding any medications except Normal Saline.
 14. Inflate antishock trousers under direction of a EMT-Paramedic.
 15. Manage patients within their scope of practice.
- B. A supervised EMT-Basic student or certified EMT-I may monitor and transport patients with peripheral lines delivering IV fluids under the following circumstances:
1. The patient's condition is not critical and is deemed stable by the transferring physician or Base Hospital Physician.
 2. The fluid infusing is a glucose solution or isotonic balanced salt solution, including Ringer's Lactate.
 3. The IV is infusing at a pre-set rate of flow. The EMT-Basic or Supervisor of the EMT-Basic student may only monitor, maintain or adjust, if necessary, to maintain a pre-set rate of flow.
 4. The patient has received no medications by the parenteral route, i.e., IM, IV, SQ, etc., or by the oral/transdermal route (other than routine oral/transdermal medications), and for at least thirty (30) minutes prior to transport.
 5. No other advanced life support equipment is attached to the patient that will require monitoring that is outside the scope of practice of the EMT-Basic.
 6. If in the prehospital setting, the patient has not received additional treatment by EMT-Paramedics that are outside the scope of practice of the EMT-Basic.

Approved:



Administration



Medical Director

SUBJECT: EMERGENCY MEDICAL TECHNICIAN-BASIC
SCOPE OF PRACTICE

Date: 07/01/03

- C. A supervised EMT-Basic student or certified EMT-Basic may monitor and transport patients, as described in B.1. above, with nasogastric (N.G.) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes, and/or indwelling vascular access lines, excluding arterial lines and uncapped central lines or other items approved by local EMS Agency.
- D. Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.
- E. An EMT-Basic who is authorized by the local authority as an EMT-Defibrillation (EMT-D) may perform defibrillation on an unconscious, pulseless patient who is apneic or has agonal respirations, while under medical control, according to established policies.
- F. An EMT-Basic student or certified EMT-Basic may utilize additional skills and/or medications included as part of pilot study as determined by the EMS Medical Director in accordance with Section 1797.214 of the Health and Safety Code, Division 2.5.

Approved:



Administration



Medical Director

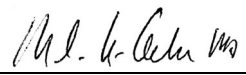
SUBJECT: IDENTIFICATION AND TRANSPORTATION
OF THE TRAUMA CENTER CANDIDATE

Date: 7/1/01

-
- I. **Authority:** Division 2.5, Health and Safety Code, Sections 1798, 1798.102 and 1798.163.
- II. **Purpose:** To establish criteria for identification of trauma center candidates to be transported to a designated trauma center.
- III. **Definitions:**
- A. **Adult** – Any trauma candidate known or appearing to be 15 years of age or older.
- B. **Pediatric** – Any trauma candidate known or appearing to be 14 years of age or less.
- IV. **Policy:**
- A. The base hospital physician/MICN shall use the following criteria to identify a trauma center candidate and the most appropriate destination for transport (see Trauma Decision Tree Algorithm attachment T-460(a)-01):
1. Physiologic Criteria: Glasgow Coma Score (GCS) < 14, Abnormal Vital Signs, Appearance, Work of Breathing and/or Circulation.
 2. Anatomic Criteria: Patients with significant anatomic injury.
 3. Mechanism of Injury: Patients sustaining a significant mechanism of injury, which may be indicative of severe underlying injury.
- B. Transportation:
1. The adult patient who is identified as a trauma candidate will be transported to the most appropriate designated adult trauma center.
 2. The pediatric patient who is identified as a trauma candidate will be transported to the most appropriate designated pediatric trauma center.

Approved:


Administration


EMS Medical Director

**SUBJECT: IDENTIFICATION AND TRANSPORTATION
OF THE TRAUMA CENTER CANDIDATE**

Date: 7/1/01

3. If there is a single ambulance (air/ground) with both a pediatric trauma center candidate AND an adult trauma center candidate, the ambulance should deliver the more critical patient to the appropriate facility. If both patients are critical, or if there are questions, both may be delivered to the designated adult trauma center. Field personnel should consider splitting the team using additional ALS transport vehicles, or air medical resources to transport the pediatric patient to a pediatric designated trauma facility and the adult to the catchment area trauma facility.
 4. If the designated pediatric trauma center is “on bypass”, pediatric trauma candidates should be delivered to the Level 1 adult designated trauma facility (UCSD).
- C. The Trauma Decision Tree Algorithm (attached) is an educational guideline to assist in identification of the trauma candidate and does not exclude a patient from identification and transportation to a designated trauma center if in the judgement of the base hospital, it is in the patient’s best interest.
- D. All Prehospital Personnel will be trained in trauma triage as part of standard agency/facility orientation curriculum and upon any changes in trauma triage criteria.

Approved:

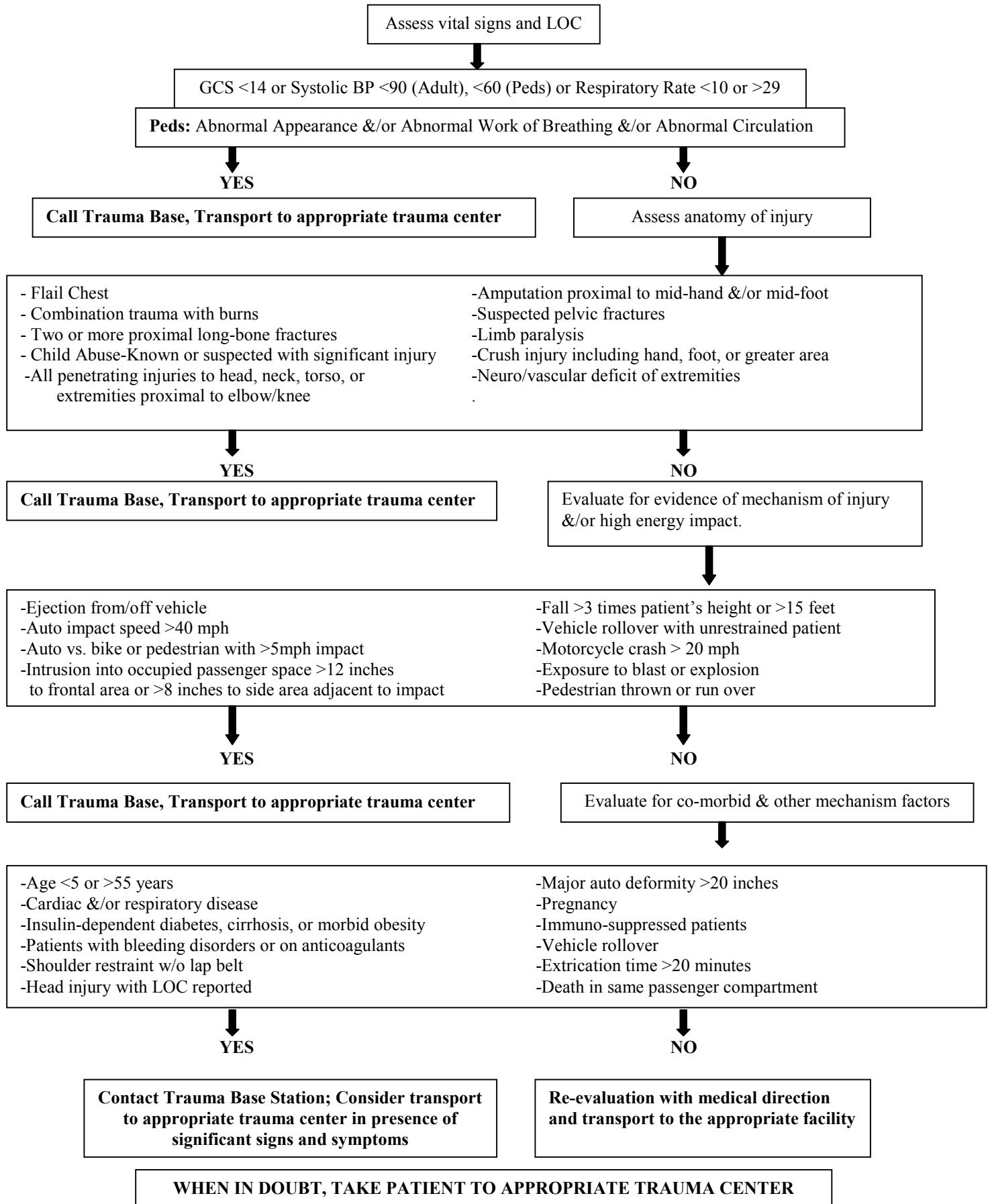


Administration



EMS Medical Director

TRAUMA DECISION TREE ALGORITHM



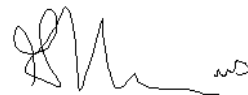
SUBJECT: AIR MEDICAL SUPPORT UTILIZATION

Date: 07/01/02

- I. **Authority:** Health and Safety Code, Section 1797.204, 1797.206, 1797.218.
- II. **Purpose:** To establish guidelines for the use of aeromedical resources within the San Diego County EMS system.
- III. **Policy:** The San Diego County EMS system shall include the utilization of authorized aeromedical resources. Refer to Air Medical Services Plan.
- A. Any public safety agency on scene or a Base Hospital may call for aeromedical support. Considerations for utilization of aeromedical transport include:
1. delay in ground transport could pose an immediate threat to the patient's health and safety,
 2. ground vs. air transport time and patient condition,
 3. extrication time,
 4. skill level of transporting ground unit,
 5. specific operational problems, precluding effective use of surface transport such as:
 - a. weather
 - b. traffic
 - c. access/egress routes
 - d. local resource capabilities during time unit will be out of service
 - e. multi-casualty incidents.
 6. Utilization of Air Ambulance or ALS rescue aircraft.
 - a. Patient's condition warrants rapid transport to medical facility.
 - b. Patient's condition requires an advanced level of care.
 - c. Multiple patient incidents when ground transport resources are insufficient.
 7. Utilization of Auxiliary rescue aircraft.
 - a. Utilize for rescue/rendezvous purposes only and shall not be for transportation to a medical



Administration



EMS Medical Director

SUBJECT: AIR MEDICAL SUPPORT UTILIZATION

Date: 07/01/02

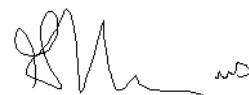
facility.

- b. Patient care shall be transferred after rescue efforts to the most appropriate level of care provider available on scene based on the patient's condition.
- c. ALS or BLS ground transport providers shall not transport the patient via Auxiliary rescue aircraft to a medical facility.

B. EMS aeromedical resources may be canceled only by the requesting party.



Administration



EMS Medical Director

SUBJECT: DOCUMENTATION AND TRANSFERRAL OF PREHOSPITAL
PATIENT CARE INFORMATION

Date: 7/1/01

-
- I. **Authority:** Health & Safety Code, Division 2.5 Section 1797.202, 1797.204, 1798.
- II. **Purpose:** To identify minimum patient documentation standards for transferral of prehospital patient information, to meet legal patient documentation requirements, enhance the continuum of care, and provide for EMS system oversight and management.
- III. **Definitions:**
- A. Prehospital Patient Record (PPR): That document, approved and required by the County and completed either electronically or on paper, that officially records prehospital patient information.
 - B. Patient Response: A response to an individual who meets any of the following criteria:
 - 1. Is an emergency patient (refer to S-412 for definition) or a patient for whom base hospital contact was made.
 - 2. Meets obviously dead criteria or who has a DNR or equivalent documentation.
 - 3. Transported by a BLS or CCT unit.
- IV. **Policy:**
- A. A PPR shall be completed for every patient response:
 - 1. Each agency making patient contact shall complete a PPR which includes personnel from that agency who participated in that patient's care (assessment, treatment, advice, transport). If an agency responds more than one vehicle, the agency may combine information onto a single PPR listing patient care personnel, or submit individual PPRs for each vehicle responding.
 - 2. In addition to the above, agencies may submit PPR's for all non-patient responses for statistical analysis by the Division of EMS.
 - 3. In all incidents involving more than one patient one form will be completed for each patient except when the County's mass casualty plan (Annex D) is activated (See Policy S-140).
-

Approved:



Administration



EMS Medical Director

SUBJECT: DOCUMENTATION AND TRANSFERRAL OF PREHOSPITAL
PATIENT CARE INFORMATION

Date: 7/1/01

- B. The PPR shall be completed in accordance with instructions provided in the County's Prehospital Patient Record Instruction Manual.
- C. When patient care is transferred, field personnel shall give a verbal patient care report to the receiving caregiver. This verbal report will relay pertinent history, vital signs, intervention, and response to treatment such that care may be transferred.

V. **Data Collection and Evaluation:**

Data collected by the Division of Emergency Medical Services from the Prehospital Patient Records and base hospital reports shall be stored by the County Division of EMS and used for overall system evaluation.

Approved:



Administration



EMS Medical Director

SUBJECT: Emergency Medical Technician/Public Safety-Defibrillation
Data Collection and Evaluation

Date: 2/15/99

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170 and 1797.204.
- II. **Purpose:** To establish a data base to effectively evaluate San Diego County's EMT/PS-D System.
- III. **Policy:**
 - A. Data essential to the evaluation of the EMT/PS-D System in San Diego County shall be collected by the Division of Emergency Medical Services in conjunction with Base Hospitals and provider agencies.
 - B. Minimum data to be collected for each EMT/PS-D patient shall include:
 1. Age.
 2. Sex.
 3. Place of occurrence.
 4. Witnessed/unwitnessed cardiac arrest.
 5. The initial monitored rhythm.
 6. Total number of defibrillatory shocks.
 7. Time in minutes from call received to first analysis.
 8. Outcome.
 9. Any bystander CPR and by whom.
 - C. The above patient data will be sent to Division of Emergency Medical Services quarterly by the fifth day of the following months: January, April, July, October.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

**SUBJECT: Emergency Medical Technician/Public Safety-Defibrillation
Data Collection and Evaluation**

Date: 2/15/99

D. Data collected by the Division of Emergency Medical Services from the EMS Prehospital Patient Record shall be stored by the Division of Emergency Medical Services, and used for overall system evaluation, while maintaining patient confidentiality.

1. The Division of Emergency Medical Services shall distribute routine reports, summarizing data received, to provider agencies and Base Hospitals. Format of these reports will be developed by the Division of Emergency Medical Services in conjunction with the provider agencies and the Base Hospitals.
2. Requests for data for specific research projects must be submitted to the Division of Emergency Medical Services by the first of the month in which the data is required.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: Transfer of Patient Data/Medical Record

Date: 2/15/99

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170, 1797.204, 1797.220 and 1798.
- II. **Purpose:** To establish guidelines in transferring and acquiring EMT/PS-D patient care data.
- III. **Policy:** Transfer of patient data shall occur in accordance with policies and procedures mutually established between provider agencies, Base Hospitals and the Division of Emergency Medical Services.
- IV. **Procedure:**
- A. Each provider agency shall develop a procedure for relinquishing the EMT/PS-D event record to the assigned Base Hospital to include:
1. The event record, and EMT/PS-D form shall be sent to the BHDMD or designee within 24 hours of the run.
 2. Event record shall be forwarded to the assigned Base Hospital representative within seven (7) days of incident.
 3. Event record will be handled in accordance with Base Hospital medical records policy.
 4. Event record is utilized for quality assurance and continuing education purposes only per San Diego County policy D-721.
- B. Transfer of patient data may occur between the Base Hospitals, provider agencies and Division of Emergency Medical Services for continuing education and quality assurance purposes.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: Esophageal Tracheal Airway Device Data Collection and Evaluation

Date: 2/15/99

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170 and 1797.204.
- II. **Purpose:** To establish a data base to effectively evaluate San Diego County's Esophageal Tracheal Airway Device (ETAD or "Combitube[®]") System.
- III. **Policy:** Data essential to the evaluation of the ETAD System in San Diego County shall be collected by the Division of Emergency Medical Services (EMS) in conjunction with base hospitals and provider agencies.
- A. Minimum data to be collected for all patients that meet criteria for ETAD insertion shall include:
1. Age of patient.
 2. Sex.
 3. Type of call - medical or trauma.
 4. Person and agency providing care.
 5. Number of attempts (successful vs. unsuccessful).
 6. Explanation if patient met criteria, and there was no ETAD insertion.
 7. Base hospital
 8. Time interval between BLS and ALS arrival.
 9. Field complication (if any) with insertion.
 10. Was ETAD replaced in field with ET?
 - a. why?
 - b. by whom?
 - c. when?
 11. Field O₂ saturation acquired by pulse oximeter (if available).
 12. ABGs on ED arrival (if available).

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: Esophageal Tracheal Airway Device Data Collection and Evaluation

Date: 2/15/99

13 Patient status (survived/expired).

- B. The above patient data shall be sent to the controlling base hospital within 48 hours for entry into the QA Net.
- C. Data collected shall be used for system and patient care improvements, assuring confidentiality of patient records.
- D. The Division of Emergency Medical Services shall distribute quarterly reports, summarizing data received, to provider agencies and base hospitals.

Approved:

Gail F Cooper

Administration

M. L. G. G. M.

Medical Director

-
- I. **Authority:** Health and Safety Code, Sections 1797.204, 1797.220, 1798.2, 1798.100, 1798.102, and 1798.104.
- II. **Purpose:** To establish a mechanism for designation of an acute care hospital as an EMT-Paramedic Base Hospital.
- III. **Policy:**
- A. To be designated as an EMT-Paramedic Base Hospital in San Diego County, the requesting institution must:
1. Comply with California Administrative Code, Title 22, Division 9, Chapter 4.
 2. Enter into an Agreement with the County of San Diego, Department of Health Services, Division of Emergency Medical Services to perform as a Base Hospital.
 3. Comply with the County of San Diego's Base Hospital Agreement.
- B. The County of San Diego, Department of Health Services, Division of Emergency Medical Services shall review its Agreement with each EMT-Paramedic Base Hospital every two years. The Agreement may be changed, renewed, canceled, or otherwise modified when necessary according to provisions for such in the Agreement.
- C. The County of San Diego, Department of Health Services, Division of Emergency Medical Services may deny, suspend, or revoke the approval of an EMT-Paramedic Base Hospital for failure to comply with applicable policies, procedures, protocols, or regulations in accordance with provisions for such in the Agreement.
- D. An additional EMT-Paramedic Base Hospital may be added to the Emergency Medical Services System on the basis of demonstrated local need.
1. Demonstrated local need shall include, but not be limited to an assessment of:
 - a. Base Hospital call volumes
 - b. Base Hospital ALS unit and prehospital personnel assignments
 - c. Current system effectiveness

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

-
2. The need for supplemental Base Hospitals shall be reviewed annually by the Department of Health Services.
 3. Tre System as it relates to the number of Base Hospitals shall be forwarded to the Board of Supervisors for approval.

IV. Procedure:

- A. Department of Health Services develops Request for Proposal (RFP) for Base Hospital Designation based on previously identified need and established Base Hospital criteria for submittal to Board of Supervisors for approval.
- B. Department of Health Services evaluates proposals, including independent review process and on-site evaluation.
- C. Department of Health Services recommends to the Board of Supervisors the addition of Base Hospital in accordance with established County Policies and State Regulations.
- D. The local EMS Agency shall approve the newly designated hospital's implementation plan. The implementation plan shall include, but is not limited to, the following:
 1. Evidence of resolution or plan for resolution of all deficiencies identified in independent review process and on-site evaluation
 2. Time line of scheduled implementation events
 3. Education - course content of in services
 4. Intra hospital policies, procedures and protocols pertaining to prehospital emergency medical care
 5. communications system
 6. Continuous Quality Improvement Program - include policies, procedures, protocols
 7. Orientation of prehospital and community to hospital's new role
 8. Outreach programs
 9. Data collection and management

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: DEDESIGNATION OF AN EMT-PARAMEDIC
BASE HOSPITAL

Date: 7/1/98 rvwd

- I. **Authority:** Division 2.5, Health and Safety Code, Section 1798.163.
- II. **Purpose:** To establish a mechanism for termination of EMT-Paramedic Base Hospital Agreement.
- III. **Policy:**
- A. Termination for Cause:
1. County may immediately terminate its agreement if a Base Hospital's license to operate as a general acute care hospital is revoked or suspended.
 2. County may immediately suspend its agreement upon written notice if a Base Hospital is in gross default of material obligation under its agreement, which default adversely affects patient care.
 3. For any other material breach of its agreement, County may terminate a Base Hospital contract for cause, if the cause is not cured within 15 days after a written notice specifying the cause is delivered. Such cause shall include, but not be limited to:
 - a. Failure to comply with material terms and conditions of the Base Hospital contract, after notice of the failure has been given.
 - b. Failure to make available sufficient personnel as required by the contract.
 - c. Gross misrepresentation or fraud.
 - d. Substantial failure to cooperate with the County's monitoring of Base Hospital services.
 - e. Substantial failure or refusal to cooperate with quality assurance and audit findings and recommendations within a reasonable time.
 4. If, within the fifteen (15) days after delivery of the written notice of cause, the material breach has not been cured to the reasonable satisfaction of the County's representative, then the County may terminate the Base Hospital contract effective as of a date specified in a written notice of termination delivered thereafter.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

**SAN DIEGO COUNTY DIVISION OF EMERGENCY MEDICAL SERVICES
POLICY/PROCEDURE/PROTOCOL**

No. P-702

Page: 2 of 2

**SUBJECT: DEDESIGNATION OF AN EMT-PARAMEDIC
BASE HOSPITAL**

Date: 3/1/90

5. If, after notice of termination of the Base Hospital contract for cause, which is not voluntarily withdrawn as stated above, it is determined for any reason that the Base Hospital was not in default under the provisions of this clause, or that the default was excusable under the provisions of this clause, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to the termination for convenience agreement.
- B. Termination for Convenience:
- Either the County or the Base Hospital may terminate the Base Hospital contract, upon forty-five (45) days written notice to the other party, as a termination for convenience.
- C. Upon the dedesignation of a Base Hospital, the local EMS Agency shall be responsible for system redesign decisions.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: TRAUMA CARE FUND

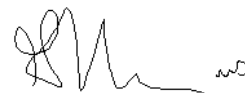
Date 7/1/2002

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- I. **Authority:** Health & Safety Code, Division 2.5, Chapter 2.5, Section 1797.198, 1797.199
- II. **Purpose:** To establish a process for the administration and disbursement of fiscal resources in the Trauma Care Fund to trauma centers based upon submission of trauma registry data
- III. **Definitions:**
- Trauma Registry Inclusion/Exclusion Criteria –**
ICD-9 code ranging between 800 to 959.9
and
Trauma center admission to a hospital **and** seen by a trauma surgeon
or
Trauma related death **and** ICD-9 code ranging between 800 to 959.9
or
Interfacility transfer in/out for a higher level of trauma care **and** ICD-9 code ranging between 800 to 959.9.
Does not include patients discharged by the Emergency Department or Trauma consult patients who were not admitted to the trauma service.
- IV. **Policy**
- A. The Trauma Care Fund has been established as a means to administer and distribute monies from the State Treasury Trauma Care Fund which have distributed to the Local Emergency Medical Services Agency based upon trauma registry data.
- B. The County will allocate 1% of any monies received into the trauma care fund for administrative costs.
- C. If additional State Treasury Trauma Fund monies are available after the minimal trauma center distribution, the County shall submit a request to the EMS Authority for additional funding. The County will develop a methodology for distribution of any additional monies above the minimum amount per trauma center that are received into the Trauma Care Fund. The Trauma Administrators Committee will function as an advisory committee to the County on distribution of the Trauma Care Fund.
- D. An application will be made to the EMS Authority for any additional trauma centers, which are designated within the County after July 1 and before January 1 of any fiscal year in which funds are distributed.
- E. If a designated trauma center de-designates prior to June 30 during a fiscal year in which it has received Trauma Care Funds, the trauma center will pay back to the County a pro rata portion of the funds it has received. The returned monies will then be distributed to the remaining trauma centers. If no designated trauma centers remain within the County, the County will return the monies to the EMS Authority.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA CARE FUND

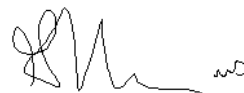
Date 7/1/2002

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- F. A contract will be completed for each designated trauma center receiving monies from the Trauma Care Fund. The contract will include:
1. Trauma registry data transmission to the County for the purposes of Trauma Care Fund distribution.
 2. Invoice mechanism for the distribution of the minimum amount of \$150,000.00 for each Level I and Level II.
 3. Distribution methodology for any remaining monies in the Trauma Care Fund.
 4. Report to the County on how the funds were used to support trauma services.
- G. The County will conduct an annual audit of the Trauma Care Fund Contract. The audit will include monitoring for compliance with:
1. Data submission requirements
 2. Distribution methodology
 3. Appropriate spending of Trauma Care Fund monies on trauma services.
- H. The County will provide trauma registry data to the Emergency Medical Services Authority within 45 days of each request.
- I. The County will utilize the standardized reporting criteria of trauma patients to the State Trauma Registry by July 1, 2003 or as determined by the EMS Authority.
- J. The County will provide to the EMS Authority an annual fiscal year report by December 31 following any fiscal year in which Trauma Care Funds were distributed.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA CATCHMENT SERVICE AREA

Date: 7/1/2002

I. **Authority:** Division 2.5 Health & Safety Code, Section 1798.161, 1798.163

II. **Purpose:** To designate catchment service areas for each designated trauma center.

III. **Definitions:**

Trauma Catchment Area – Geographic Area with defined boundaries assigned to a designated trauma center for purposes of care of patients identified as trauma candidates.

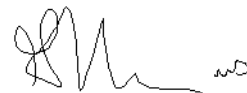
IV. **Policy:**

- A. The adult patient who is identified as a trauma candidate will be transported to the most appropriate adult trauma center assigned per geographic designation per policy T-460: Identification and Transportation of the Trauma Center Candidate, the Trauma Catchment Area Boundary Guidelines and the San Diego Trauma Catchment Maps.
- B. The pediatric patient who is identified as a trauma candidate will be transported to the most appropriate pediatric trauma center per geographic designation per policy T-460: Identification and Transportation of the Trauma Center Candidate, the Trauma Catchment Area Boundary Guidelines and the San Diego Trauma Catchment Maps.

Approved:



Administrator



Medical Director

SUBJECT: ROLE OF THE PEDIATRIC TRAUMA CENTER

Date: 7/1/2002

I. **Authority:** Health & Safety Code, Division 2.5 Chapter 6. Section 1798.165 and 1799.205.

II. **Purpose:** To define the role and requirements of a designated pediatric trauma center.

III. **Definitions:**

Pediatric Trauma Center – a facility which has been designated by the San Diego County Division of Emergency Medical Services to provide comprehensive care to the injured pediatric patient <15 years of age, who meets major trauma candidate criteria.

IV. **Policy:**

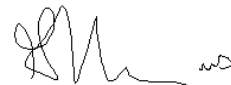
A Pediatric Trauma Center shall:

- A. Meet or exceed compliance standards set forth within the San Diego County Pediatric Trauma Center Agreement.
- B. Participate in the Committee on Pediatric Emergency Medicine (COPEM), providing expertise in pediatric trauma care issues.
- C. Participate in injury prevention and community education activities related to children.

Approved:



Administrator



Medical Director

**SUBJECT: TRAUMA CARE COORDINATION WITHIN THE TRAUMA
SYSTEM**

Date: 7/1/2002

- I. Authority:** Health and Safety Code, Division 2.5, Sections 1797.200 and 1798.163
- II. Purpose:** To define the coordination of trauma care within the San Diego County Emergency Medical Services System, and with neighboring jurisdictions.
- III. Policy**

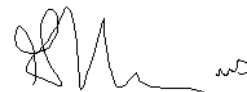
The Health & Human Services Agency, Division of Emergency Medical System (EMS) is required to assure coordination of trauma care services and trauma system compliance with state and local regulations. This shall be accomplished through the following System design that assures:

- A. Adequate numbers of trauma centers to meet the needs of the population and incidents of trauma in the county.
- B. A coordinated response for the provision of advanced life support (ALS) and trauma care services within and around San Diego County through ALS inter-county agreements with neighboring and remote EMS jurisdictions.
- C. Active duty military personnel and their dependants involved in traumatic incidents are integrated into the San Diego County Trauma System.
- D. System oversight to assure that patients needing trauma services receive such services, including:
 - 1. Transportation of trauma patients to designated trauma facilities.
 - 2. Required personnel and resources to provide the appropriate level of service are available at designated trauma facilities.
 - 3. The trauma registry is maintained for the purpose of monitoring system operations.
 - 4. A quality monitoring system that assures compliance with all applicable state laws, regulations and local policies, procedures and contractual arrangements.
 - 5. Public awareness and education on injury prevention.

Approved:



Administrator



Medical Director

SUBJECT: DESIGNATION OF A TRAUMA CENTER

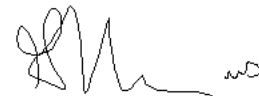
Date: 7/1/2002

- I. **Authority:** Division 2.5 Health and Safety Code, Section 1798.164, 1798.165
- II. **Purpose:** To define the process and procedure for designating a Trauma Center to the Trauma Care System.
- III. **Definitions:**
- IV. **Policy**
- A. The need for additional designated Trauma Centers shall be determined by the Health & Human Services Agency, Division of Emergency Medical Services. An additional Trauma Center may be added to the Trauma Care System on the basis of demonstrated local need, which shall include, but not be limited to an assessment of:
 - 1. Prehospital response times
 - 2. Population shifts/increases
 - 3. Current system effectiveness
 - 4. Available prehospital/hospital resources
 - B. The Board of Supervisors shall approve recommendations as to the number of Trauma Centers.
 - C. The designation of an additional trauma center will via a competitive bid process.
 - D. Upon designation, each trauma center will pay an initial and thereafter annual fee of \$40,000.00 per year to the County of San Diego, Division of Emergency Medical Services.

Approved:



Administrator



Medical Director

SUBJECT: DESIGNATION OF A TRAUMA CENTER

Date: 7/1/2002

- E. The designation of a trauma center for purposes of the Emergency Medical Services System of the County of San Diego confers upon the facility, the recognition that it has the commitment, personnel and resources necessary to provide optimum medical care for the trauma patient.
- F. Each trauma center shall meet the criteria set forth in the trauma center agreement and demonstrate a continuous ability and commitment to comply with policies, protocols and procedures developed by the Division of Emergency Medical Services.
- G. Each trauma center shall undergo an annual performance evaluation based upon the trauma center agreement. Results of the evaluation shall be made available to the facility.
- H. All designated trauma centers shall participate in the quality improvement process per the Quality Assurance Manual.

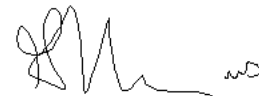
V. Procedure:

- A. Health & Human Services Agency, Division of Emergency Medical Services develops and distributes a Request for Proposal (RFP) for Trauma Center Designation.
- B. Health & Human Services Agency, Division of Emergency Medical Services evaluates the proposals, including independent review process and on-site evaluation and makes recommendations to the Board of Supervisors.

Approved:



Administrator



Medical Director

SUBJECT: DE-DESIGNATION OF A TRAUMA CENTER

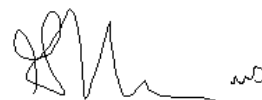
Date: 7/1/2002

- I. **Authority:** Division 2.5, Health and Safety Code, Section 1798.163.
- II. **Purpose:** To establish a policy and procedure for de-designation of a trauma center.
- III. **Policy**
- A. Termination for Cause:
1. County may immediately terminate its Trauma Center Agreement if a trauma center's license to operate as a general acute care hospital is revoked or suspended.
 2. County may immediately suspend its Agreement upon written notice if a trauma center is in gross default of material obligation under its Agreement, which default could adversely affect patient care provided by Contractor.
 3. For any other material breach of its agreement, County may terminate a trauma center contract for cause, per the language of the Agreement. Such cause shall include, but not be limited to:
 - a. Failure to comply with material terms and conditions of the trauma center contract, after notice of the failure has been given.
 - b. Failure to make available sufficient, qualified personnel and hospital resources to provide immediate care for trauma patients as required by Section C of the contract.
 - c. Failure to provide timely surgical coverage for trauma patients as required by Section C of the contract.

Approved:



Administrator



Medical Director

SUBJECT: DE-DESIGNATION OF A TRAUMA CENTER

Date: 7/1/2002

- d. Failure to provide physicians, surgeons, and other medical, nursing and ancillary staff who possess that degree of skill and learning ordinarily possessed by reputable medical personnel in like or similar localities and under similar circumstances for the provision of trauma center medical services.
- e. Gross misrepresentation or fraud.
- f. Substantial failure to cooperate with the County's monitoring of trauma center services and base hospital services.
- g. Substantial failure or refusal to cooperate with quality assurance and audit findings and recommendations within a reasonable time.

B. Termination for Convenience:

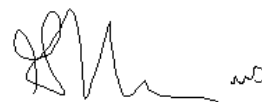
Either the County or the Trauma Center may terminate the trauma center contract, as a termination for convenience per the language of the Agreement.

C. Upon the de-designation of a trauma center, the local EMS Agency shall be responsible for system redesign decisions.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA CENTER BYPASS

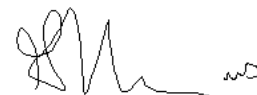
Date: 7/1/2002

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- I. **Authority:** Division 2.5, Health and Safety Code, Section 1798.163.
- II. **Purpose:** To establish criteria for trauma center bypass.
- III. **Policy:**
- A. The in-house trauma surgeon is responsible for determining bypass status of his/her Trauma Center and will utilize the following criteria for making this determination. The Trauma Center may go on bypass status if one of the following criteria is met:
 - 1. Time (30 minutes) is needed to obtain a backup trauma surgeon, neurosurgeon or anesthesiologist because the primary physician is occupied with another trauma patient.
 - 2. Time (1 hour) is needed to identify a second operating room because the primary room is being utilized and another is not readily available.
 - 3. Two or more trauma patients with major injuries are being resuscitated in the trauma room (1 hour).
 - 4. The hospital is closed due to internal disaster.
 - 5. The trauma center is activated during an external disaster (Annex D).
 - 6. Time (1 hour) the CT scanner is being serviced or is broken. The trauma center can accept penetrating injuries excluding head or neck.
 - B. When a trauma center is on bypass, the patient should be redirected to another trauma center, taking into consideration transport time, the patient's medical needs and the institution's available resources.
 - C. Trauma center personnel will immediately enter both the initiation and reasons/conditions for bypass into the San Diego County EMS Wide Area Communication Network (QANet). At the time of change in condition of trauma center bypass status, trauma center personnel shall update the San Diego County EMS Wide Area Communication Network (QANet).
 - D. The trauma center will provide reviews of variations from this policy to the Medical Audit Committee via the Division of EMS as requested for purposes of trauma system quality assurance.
 - E. A trauma center should use its best efforts to limit bypass to less than 5% of the total available hours on a monthly basis.

Approved:



Administrator



Medical Director

SUBJECT: RESOURCES FOR TRAUMA TEAM RESPONSE

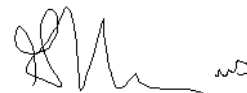
Date: 7/1/2002

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- I. **Authority:** Health & Safety Code, Division 2.5, Section 1798.163
- II. **Purpose:** To identify the trauma center resources, which must be available for trauma team activation
- III. **Definitions:**
Immediately Available – means unencumbered by conflicting duties or responsibilities; responding when notified without delay; and being within the specified resuscitation area of the trauma center when the patient is delivered.
- Promptly Available – means responding without delay when notified and requested to respond to the hospital; and being physically available to the specified area of the trauma center within a period of time that is medically prudent (within 30 minutes, 24 hours per day, 7 days per week).
- IV. **Policy**
- A. The following resources shall be available for trauma center candidates requiring full trauma team activation:
1. Immediately Available:
 - a. Qualified Trauma Surgeon
 - b. Emergency Department Physician
 - c. Trauma Resuscitation Nurse responsible for the supervision of nursing care during the resuscitation phase
 - d. Registered Nurse currently trained in trauma patient care to perform care duties, scribe, etc
 - e. Respiratory Therapy
 - f. Radiology
 - g. Laboratory
 - h. Operating Room
 - i. Pharmacy
 2. Promptly Available:
 - a. Trauma Consultants as requested by the Trauma Surgeon
- B. Trauma center candidates not requiring full trauma team activation require, at a minimum, the following resources with a physical evaluation by the Trauma Surgeon:
1. Qualified Trauma Surgeon
 2. Emergency Department Physician

Approved:



Administrator



Medical Director

SUBJECT: RESOURCES FOR TRAUMA TEAM RESPONSE

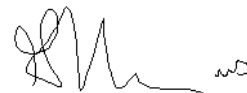
Date: 7/1/2002

- 3. Registered Nurse currently trained in trauma patient care.
- C. The use of a tiered trauma response is encouraged in an effort to conserve resources and reduce the cost of trauma care.
- D. All departments involved in the delivery of trauma care must have equipment and supplies for all ages of patients as approved by the Medical Director of the Service in collaboration with the Trauma Medical Director.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA SERVICE CONSULTATION FOR THE COMMUNITY Date: 7/1/2002

I. **Authority:** Health & Safety Code, Division 2.5, Health and Safety Code, Section 1798.163.


II. **Purpose:** To establish the criteria for trauma consultation with community physicians.

III. **Policy**

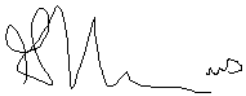
A San Diego County Trauma Center shall provide:

- A. Medical consults with community physicians and providers regarding the immediate management of trauma patients.
- B. Trauma care information, education and follow-up to other medical care providers in their service area on a routine basis. The Trauma Medical Director or designee shall meet with satellite hospital personnel for this purpose when necessary.

Approved:



Administrator



Medical Director

SUBJECT: TRANSFER OF STABLE TRAUMA SERVICE
HEALTH PLAN MEMBERS

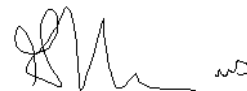
Date: 7/1/2002

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- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1798.163 and 1798.172
- II. **Purpose:** To establish guidelines for transfer of stable trauma patients to their health plan's facility.
- III. **Policy**
- A. It is the intent of the trauma system to transfer stable trauma patients to their health plan provider's facility when requested, as long as such transfer is medically prudent and in the best interest of the patient. All requests/discussions concerning transfer status of the patients will be made physician to physician. Transfer agreement will be based on patient condition and appropriateness of receiving facility resources.
 - B. Unless otherwise decided by the trauma surgeon of record, no patient requiring acute care admission will be transferred to a hospital that is not a designated trauma center in less than twenty-four hours.
 - C. The decision as to transfer of post-operative, intensive care or other acute care patients lies solely with the trauma surgeon of record.
 - D. Hospitals which have accepted transfer of a trauma patient from a designated trauma center shall:
 - 1. Provide the information required to complete the trauma registry on that patient to the transferring trauma center.
 - 2. Participate in system and trauma center quality improvement activities for that patient who has been transferred.
 - E. Trauma center candidates cared for at San Diego County designated trauma centers may require extensive diagnostic evaluation or immediate treatment. Trauma center evaluation does not necessitate pre-approval by the patient's insurer.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA CENTER INJURY PREVENTION ACTIVITIES

Date: 7/1/2002

- I. **Authority:** Health & Safety Code, Division 2.5 Chapter 6 Section 1798.163
- II. **Purpose:** To establish minimum standard for designated trauma center injury prevention activities/programs.
- III. **Policy:**
- A. Each designated trauma center will participate in injury prevention activities.
 - B. Prevention activities may be autonomous or collaborative with existing organizations/agencies and/or other designated trauma centers (individually or as a system).
 - C. Injury prevention topics will be based upon:
 - 1. Identification of injury trends through utilization of the trauma registry.
 - 2. Community mortality data provided by the Medical Examiners Office.
 - 3. Community identified injury risks (may be seasonal).
 - D. Prevention activities/programs will be based upon identified need and include objective goals and outcome evaluation.

Approved:



Administrator



Medical Director

SUBJECT: PUBLIC INFORMATION & EDUCATION
ON TRAUMA SYSTEMS

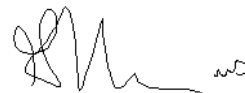
Date: 7/1/2002

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- I. **Authority:** Health & Safety Code, Division 2.5 Chapter 6, Section 1798.163, California Code of Regulations, Title 22, Division 9, Section 100255 (r).
- II. **Purpose:** To establish minimum standards for designated trauma centers to participate in public information and education about the trauma system.
- III. **Policy**
- A. Each designated trauma center will participate in providing the public/community with information and education regarding the San Diego County Trauma System.
 - B. Public Information and Education programs may be autonomous or collaborative with existing organizations/agencies and/or with other designated trauma centers.
 - C. Public Information and Education may be incorporated into Injury Prevention Programs and other public information venues.

Approved:



Administrator



Medical Director

SUBJECT: TRAUMA PROVIDER MARKETING AND ADVERTISING
Draft

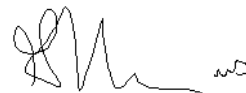
Date: 7/1/2002

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- I. **Authority:** Health & Safety Code, Division 2.5, Sections 1789.163, 1798.165
- II. **Purpose:** To provide a guideline for the utilization of the trauma terminology in marketing and advertising by a trauma care provider within the San Diego Emergency medical Services System.
- III. **Policy**
The Division of Emergency Medical Services (EMS) has the responsibility to authorize use of the term "Trauma" in marketing and advertising by any health or trauma care provider.
- A. In accordance with Section 1798.165 of the Health & Safety Code, "No health care provider shall use the terms; trauma facility, trauma hospital, trauma center, trauma care provider, trauma vehicle or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the local EMS agency".
- B. Requests for such authorizations are to be submitted to the EMS Coordinator for Trauma at the Division of Emergency Medical Services.

Approved:



Administrator



Medical Director

SUBJECT: Designation of Emergency Medical Technician/Public Safety-
Defibrillation Base Hospital

Date: 3/1/91

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170, 1797.204, 1797.220, 1798, 1798.2, 1798.100 and 1798.104.
- II. **Purpose:** To establish a standard mechanism for approval and designation as an EMT-D/PS-D Base Hospital.
- III. **Policy:**
- A. To be designated as an EMT-D/PS-D Base Hospital in San Diego County, the requesting institution shall be currently designated as a Base Hospital complying with all requirements, policies, procedures and protocols for a Base Hospital in San Diego County.
- B. An EMT-D/PS-D Base Hospital may delegate any or all of the following to a specified satellite hospital or provider agency if approved by the Base Hospital Medical Director:
1. Field care audits.
 2. Structured training sessions.
 3. Defibrillation skill proficiency demonstrations.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: **Quality Assurance For Emergency Medical Technician/Public
Safety-Defibrillation**

Date: 2/15/99

-
- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.170, 1797.204 and 1798 and 1708.102.
- II. **Purpose:** To establish minimum requirements for quality control and assurance of appropriate patient care.
- III. **Policy:**
- A. The Base Hospital shall establish policies and procedures to review runs to include the following:
 - 1. Written documentation of compliance/noncompliance of protocols on each run, information to be obtained from the event record.
 - 2. All shockable rhythms to identify trends or deficiencies and follow-up according to Base Hospital quality assurance process.
 - B. Prehospital issues reportable to PAC.
 - 1. Malfunctions of the AED machine.
 - 2. Functioning outside of the scope of practice.
 - 3. Repeated deviations of policies/protocols.
 - 4. Deviations from safety guidelines.
 - C. The following deviations and deficiencies shall be reported verbally to the Division of Emergency Medical Services within 48 hours with written documentation to follow.
 - 1. Functioning outside of the scope of practice.
 - 2. Deviations from safety guidelines resulting in injury.
 - D. The Base Hospital and agency shall establish policies to deal with event record storage, retrieval, and disposal. The event record is to be utilized for quality assurance and continuing education purposes only.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: DESIGNATION OF PROVIDERS OF
ADVANCED LIFE SUPPORT SERVICE

Date: 11/1/96

- I. **Authority:** Health & Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.218, 1797.220; California Code of Regulations, Division 9, Chapter 4, Article 5.
- II. **Purpose:** To approve and designate Emergency Medical Technician-Paramedic (EMT-P) service providers in San Diego County.
- III. **Definitions:**
- A. Advanced Life Support (ALS) response: Any medical aid call in which EMT-Ps are dispatched to the scene on a ground transporting unit, and/or any call that has been screened or prioritized in accordance with an approved dispatch plan as necessitating an advanced life support level of response.
 - B. Basic Life Support (BLS) response: Any medical aid call that has been screened or prioritized in accordance with an approved dispatch plan to a non-paramedic (EMT-I) level of response.
 - C. Approved Dispatch plan: A dispatch plan approved by the San Diego County Division of Emergency Medical Services (EMS).
- IV. **Policy:**
- A. To be designated as an EMT-P service provider in San Diego County, a local jurisdiction (a local jurisdiction is the County, a city, water district, fire protection district, hospital district or county service area), or air medical provider designated as a primary response provider in accordance with the San Diego County Air Medical Services Plan, shall:
 - 1. Enter into a written agreement with the County of San Diego to perform as an EMT-P service provider.
 - 2. Provide ALS service on a continuous 24 hour basis.
 - 3. Provide emergency medical responses in accordance with the following requirements:
 - a. Ground ALS Response: Ensure that at least two EMT-Ps are initially responded to each ALS response, and that a ground transport vehicle is simultaneously dispatched to all ALS responses,

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: DESIGNATION OF PROVIDERS OF
ADVANCED LIFE SUPPORT SERVICE

Date: 11/1/96

unless an alternate dispatch plan which has been approved by the Division of EMS is in effect.

In systems which respond ALS first responder units, the ALS first responder shall be equipped in accordance with EMS Policy P-806 "ALS First Responder Inventory".

- b. Air Medical Primary ALS Response: Ensure that all primary response ALS aircraft are staffed in accordance with the provisions of the San Diego County Air Medical Plan, maintaining a minimum staffing level of one registered nurse and one EMT-P as flight crew.
4. Require that EMT-Ps establish base hospital contact as outlined in San Diego County Division of Emergency Medical Services Policy S-415.
5. Require that paramedics maintain current American Heart Association CPR/Health Care Provider status or American Red Cross equivalent.
6. Require that all EMT-Ps working as a part of the EMS system maintain San Diego County EMT-P Accreditation (Policy P-305)
7. Integrate with a first responder system.
8. Enter into mutual aid agreement with adjoining EMT-P agencies whenever possible.
9. Establish the following planned response times:
 - a. Provide for a planned maximum ground ALS response time of no more than *30 minutes 90% of the time* in rural areas and no more than *10 minutes 90% of the time* in urban areas. In systems that incorporate ALS First Responders, the provider shall plan for a maximum ALS First Responder arrival time of *8 minutes 90% of the time* with a maximum ALS ground transport response time of *12 minutes 90% of the time*.
 - b. Provide a maximum ground BLS response time of no more than *15 minutes 90% of the time* in urban areas and no more than *30 minutes 90% of the time* in rural areas.
10. Cooperate with the EMT-P training agencies in providing paramedic field internship placements.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

**SUBJECT: DESIGNATION OF PROVIDERS OF
ADVANCED LIFE SUPPORT SERVICE**

Date: 11/1/96

11. Provide orientation for first responder agencies to advanced life support functions and role.
 12. Designate an agency paramedic coordinator.
 13. Submit prehospital patient records via approved San Diego County EMS Form 104 or via electronic means on the San Diego County Quality Assurance Network (as per Policy S-602).
 14. Agree to participate in community education programs to teach the public access to paramedic services and CPR.
 15. Submit to the Division of EMS, evidence of compliance with the California Code of Regulations, Title 22, Division 9, Chapter 4, Article 5.
 16. Develop internal activities for quality assurance mechanisms based on policies/procedures as cited by County EMS and Base Hospital policies (see S-004).
 17. Contract with a designated base hospital to provide medical direction and supervision to assigned air medical EMT-P personnel (designated primary response air medical providers only).
- B. The County of San Diego shall:
1. Approve paramedic curriculum and training programs.
 2. Provide standards for accreditation/authorization and reaccreditation/ reauthorization of EMT-Ps and MICNs in the County.
 3. Contract with designated base hospitals to provide immediate medical direction and supervision of assigned prehospital personnel.
 4. Provide prehospital patient record forms or alternate electronic reporting mechanism (Quality Assurance Network).
 5. Review agreements with each EMT-P service provider every two years.
- C. The County of San Diego has the right to revoke, or suspend approval of an EMT-P service provider for failure to comply with applicable policies, procedures, protocols or regulations.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SAN DIEGO COUNTY DIVISION OF EMERGENCY MEDICAL SERVICES
POLICY/PROCEDURE/PROTOCOL

No. S-803

Page: 1 of 2

SUBJECT: Recovery of Prehospital Patient Care Reusable Equipment

Date: 7/1/99

- I. Authority: Health and Safety Code, Division 2.5, Section 1797.204.
- II. Purpose: To secure and return reusable equipment to the prehospital care provider.
- III. Policy:
 - A. All participants in the EMS system shall facilitate the return of properly labeled equipment to the owner agency.
 - B. All agencies in the EMS system agree to buy and stock enough equipment so as not to be dependent upon another agency for immediate item replacement/exchange when faced with normal average workloads.
- IV. Procedure:
 - A. Prehospital Agency Responsibilities:
 1. Agencies shall permanently label all reusable equipment in the following manner:
 - a. Agency name and telephone number.
 - b. "Return to Emergency Department." (optional)
 2. Agencies shall make their best effort to recover equipment within seven (7) days.
 3. Prehospital personnel shall log equipment as required by their agency.
 - B. Hospital Responsibilities:
 1. Hospitals shall provide a logbook or similar mechanism to assist in keeping track of equipment left in the hospital.
 2. Hospitals shall be responsible for security on reusable prehospital equipment left in the hospital for up to seven (7) days, when the provider agency has:
 - a. Clearly labeled equipment with agency name and telephone number.
 - b. Agency personnel have provided written documentation regarding equipment left in the hospital in the log provided for equipment identification.

Approved:


Administration


Medical Director

SAN DIEGO COUNTY DIVISION OF EMERGENCY MEDICAL SERVICES
POLICY/PROCEDURE/PROTOCOL

No. S-803

Page: 2 of 2

SUBJECT: Recovery of Prehospital Patient Care Reusable Equipment

Date: 7/1/99

3. Hospitals shall not release equipment to any agency but the owner agency, unless there is prior approval by the owner agency.
4. Hospitals shall make every attempt to remove visible contaminants prior to placing equipment in a common storage area.
5. Contaminated equipment that cannot be visibly cleaned will be put in a non-red transparent bag, labeled "BIOHAZARD - TO BE CLEANED."

Approved:



Administration



Medical Director

SUBJECT: ALTERNATE EMT-PARAMEDIC SERVICE PROVIDER
APPLICATION/DESIGNATION

Date: 9/1/91

- I. **Authority:** Health and Safety Code, Division 2.5, Sections 1797.201, 1797.204, 1797.218, and 1797.224.
- II. **Purpose:** To encourage the establishment of new advanced life support (ALS) services in low population density areas that have demonstrated hardship in establishing services at the community standard of care.
- III. **Definitions:**
- A. Alternate Advanced Life Support (ALS): ALS provided in low population density areas utilizing an EMT-Paramedic staffing option other than the current community standard in San Diego County.
 - B. Community Standard: two (2) EMT-paramedics on each advanced life support unit with twenty-four (24) hour per day coverage and a response time of ten (10) minutes or less (urban) and fifteen (15) minutes or less (rural) 90% of the time.
 - C. Low population density area: service area wherein a population does not exceed 750 residents per square mile and is not less than 100 residents per square mile, or where sufficient non-resident or other usage can be demonstrated to justify the service.
 - D. Hardship is one or more of the following situations:
 - 1. Financial hardship such that service at the community standard of care is impossible.
 - 2. A local system or organizational hardship such that:
 - a. Service cannot be made generally available throughout the service area within established response time guidelines utilizing a community standard service configuration; or
 - b. Service cannot be made available through eligible provider at the community standard without compromising other public safety mission requirements; or
 - c. No new provider can or will enter the service area and provide service at the community standard.

Approved:

Gail F Cooper

Administration

M. L. G. Allen MD

Medical Director

SUBJECT: ALTERNATE EMT-PARAMEDIC SERVICE PROVIDER
APPLICATION/DESIGNATION

Date: 9/1/92

IV. Procedure:

A. Application Process:

1. Submit a letter of intent to establish ALS services, in writing, to the Health and Human Services Agency, Division of EMS.
2. Conduct a competitive bid process pursuant to Health and Safety Code, Division 2.5, Section 1797.224, and in accordance with local policies.
3. Following a competitive bid process, submit to the Division of EMS:
 - a. Copy of all proposals or responses received.
 - b. Statement of need of ALS services in defined area.
 - c. Data which supports a claim of hardship in establishing ALS services in accordance with established current community standards.
 - d. Description of alternate ALS model proposed.
 - e. Description of financial viability for alternate program.
 - f. Other special issues unique to the community which may directly or indirectly impact the ability to provide ALS services at the community standard of care.
4. Within 90 days of receipt of above documents, the Division of EMS will:
 - a. Review all documents.
 - b. Conduct a community survey (on an as needed basis).
 - c. Make a determination of the need for alternate ALS to the specified community.
 - d. Notify the applicant(s) of the final decision and any recommendations or suggestions for implementation.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: ALTERNATE EMT-PARAMEDIC SERVICE PROVIDER
APPLICATION/DESIGNATION

Date: 9/1/92

B. Designation Process:

1. To be designated as an alternate EMT-Paramedic service provider in San Diego County, a local jurisdiction (a local jurisdiction is the County, a city, water district, fire protection district, or county service area), which has been approved by the County of San Diego to provide alternate ALS services must:
 - a. Comply with California Code of Regulations, Title 22, Division 9, Chapter 4.
 - b. Enter into an Agreement with the County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services to perform as an alternate EMT-Paramedic service provider agency.
 - c. Comply with all responsibilities of the contractor as outlined in Exhibit A.
2. The County of San Diego, Department of Health, Division of EMS shall review the Agreement with the alternate EMT-Paramedic service provider every two (2) years. The Agreement may be changed, renewed, canceled, or otherwise modified when necessary according to provisions for such in the Agreement.
3. The County of San Diego, Division of EMS may deny, suspend, or revoke the approval of an alternate EMT-Paramedic service provider agency for failure to comply with applicable policies, procedures, protocols, or regulations in accordance with provisions for such in the Agreement.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

EXHIBIT A

RESPONSIBILITIES OF THE CONTRACTOR

1. To provide EMT-Paramedic Services within the boundaries of its local jurisdiction, and within adjoining areas as specified by Agreements with adjoining EMT-Paramedic Service Providers.
2. To participate in the Advanced Life Support (ALS) Program in accordance with Title 22 of the California Code of Regulations, Division 9, Chapter 4.
3. To develop and operate EMT-Paramedic Services in accordance with California Code of Regulations, Title 22, Division 9, Chapter 4. The **CONTRACTOR** may subcontract all or a portion of these services. However, the **CONTRACTOR** is responsible for insuring that any and all subcontractors provide services in accordance with California Code of Regulations, Title 22, Division 9, Chapter 4.
4. To maintain and operate at least one fully equipped, supplied and staffed EMT-Paramedic Unit seven days a week, twenty-four (24) hours a day, in accordance with the Policies, Procedures and Protocols established by San Diego County.
5. To staff each unit with at least one (1) EMT-P at all times. For the purpose of this Agreement, an EMT-P is an individual certified in the State of California as an EMT-Paramedic, and accredited by the San Diego County Emergency Medical Services Medical Director to operate as an EMT-Paramedic in San Diego County, pursuant to Section 1797 et seq. of the Health and Safety Code.
6. To staff each unit with at least one (1) EMT-IA at all times. For the purpose of this Agreement, an EMT-IA is an individual certified in the State of California to operate as an EMT-IA, pursuant to Section 1797 et seq. of the Health and Safety Code.
7. To provide the citizens of the local jurisdiction with information on the 9-1-1 system and where and how to obtain Cardiopulmonary Resuscitation (CPR) training.
8. To ensure that all EMT-Paramedic personnel comply with the continuous accreditation requirements of the **COUNTY**.

EXHIBIT A

RESPONSIBILITIES OF THE CONTRACTOR (continued)

9. To provide suitable facilities for housing the EMT-P unit(s).
10. To cooperate with the approved EMT-Paramedic training programs in providing field internship locations for paramedic interns.
11. To develop mutual aid and/or call-up plans for providing EMT-Paramedic Service in an area in the event the ambulance assigned to the area is not operable, or is away from the area for other reasons. Automatic response plans may be developed by the local jurisdiction with concurrence of adjoining EMT-Paramedic services.
12. To notify the Chief, Division of Emergency Medical Services, or designee, immediately whenever any condition exists which adversely affects the local jurisdiction's ability to meet the conditions of this Agreement.
13. To appoint an Agency Paramedic Coordinator, to serve as liaison between the Agency, the County, base hospitals, receiving hospitals, BLS provider agencies and public safety agencies operating within the service area.
14. To provide orientation for first responder agencies to advanced life support functions and role.
15. To provide for a planned maximum response time of no more than fifteen (15) minutes in rural areas and no more than ten (10) minutes in urban areas.
16. To participate in local Emergency Medical Service planning activities, including disaster management.
17. To comply with all applicable State statutes and regulations and County standards, policies, procedures and protocols, including a mechanism to assure compliance.
18. To implement and maintain a Quality Assurance program.
19. To take immediate corrective action where there is a failure to meet "Responsibilities of the **CONTRACTOR**".

SUBJECT: Advanced Life Support First Responder Units

Date: 7/1/97

- I. Authority:** Health and Safety Code, Division 2.5, Section 1797.204, 1797.218, and 1797.220.
- II. Purpose:** To provide a mechanism for designated Emergency Medical Technician-Paramedic (EMT-P) service providers in San Diego County to provide early advanced life support (ALS) level assessment and initial life saving treatment to patients by an EMT-P prior to the arrival of the ALS transport unit.
- III. Definitions:**
- A. An ALS first responder unit is defined as a non-transporting emergency response vehicle utilized for responses by a designated EMT-P service provider which is staffed by at least one (1) EMT-P and one (1) EMT-I, and which complies with the operational criteria outlined in this policy.
 - B. A standard ALS unit is defined as a transporting emergency response vehicle utilized for response and/or transport by a designated EMT-P service provider which complies with the operational criteria as outlined in San Diego County Division of Emergency Medical Services (EMS) policies P-801 and P-802.
- IV. Policy:**
- A. Staffing for an ALS first responder unit in San Diego County shall include at a minimum one (1) EMT-P and one (1) EMT-I. ALS first responder units shall be equipped with standardized inventory as specified in San Diego County Division of EMS policy P-806.
 - B. The closest available standard ALS unit shall be dispatched simultaneously with the ALS first responder unit if the response meets established criteria for dispatch of an ALS unit. If a standard EMT-P unit is not available and ALS interventions are needed, the ALS first responder unit EMT-P shall make base hospital contact per San Diego County Policy. If ALS care is initiated, and the standard ALS unit remains unavailable, the ALS first responder unit EMT-P shall accompany the patient to the hospital in a BLS ambulance. Each ALS first responder unit will be assigned a base hospital by the local EMS agency.
 - C. Approved service provider agencies must provide a mechanism for direct field observation of the ALS first responder unit by base hospital personnel and the local EMS agency or designee. Approved service provider agencies shall have a current ALS service provider agreement with the San Diego County

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: Advanced Life Support First Responder Units

Date: 7/1/97

Division of EMS.

V. Procedure:

A. Application/approval process:

Application for use of ALS first responder unit(s) shall be submitted in writing to the Medical Director, San Diego County Division of Emergency Medical Services and shall include:

1. Identification, location, and average response times of the transporting ALS unit assigned to the geographical area.
2. Identification, location, and average response times of the proposed ALS first responder unit(s).
3. Description of the proposed ALS first responder unit staffing, to include level(s) of training.
4. A statement indicating what optional equipment (if any) will be included in the inventory of the ALS first responder unit. (telemetry radio, monitor defibrillator, medications)
5. An adopted policy indicating provider agency commitment that established two (2) person ALS units shall not be downgraded or removed as a result of the ALS first responder unit(s).

B. Operational requirements:

When the ALS first responder unit arrives on scene prior to the standard ALS unit, the paramedic shall:

1. Assess the patient.
2. Institute basic life support if indicated.
3. Institute ALS care per San Diego County Division of EMS protocols, if indicated.
4. Initiate base hospital contact if additional orders are needed or standard ALS unit is unavailable to respond.
5. Transfer care of patient to EMT-Ps on the standard ALS unit upon its arrival.
6. Cancel the standard ALS unit if ALS services are not required.
7. Submit completed prehospital patient records in accordance with policy S-602.

Approved:

Gail F. Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: **ALS First Responder Inventory**

Date: 7/1/02

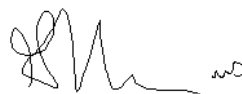
- I. **Authority:** Health and Safety Code, Division 2.5, Section 1797.204
- II. **Purpose:** To identify standardized inventory for all assessment units.
- III. **Policy:** Essential equipment and supplies to be carried on each ALS first responder unit shall include at a minimum the following:

A. <u>Airway Adjuncts:</u>	<u>Minimum</u>
Aspiration based endotracheal tube placement verification device	2 each
Esophageal Tracheal Double Lumen Airway Kit (Combitube): Reg, Small Adult	2 each
Intubation tubes: sizes: 2.5, 3.5, 4.5, 5, 6, 6.5, 7, 7.5, 8, 8.5, 9	1 each
Laryngoscope - blade: curved and straight sizes 2,3,4	1 each
Laryngoscope - handle	2 each
Magill tonsil forceps	1 each
Nasal Airways-assorted sizes	1 pkg
O ₂ powered nebulizer	1 each
O ₂ cannula	2 each
Stylet (pediatric, adult)	1 each
Suction catheters (5, 6, 8, 10, 12, 14, 18 fr)	1 each
Suction catheters, tonsil tip (Yankauer)	3 each
Water soluble lubricant	1 each
End-tidal CO ₂ detector (pediatric <i>and</i> adult)	2 each
 B. <u>Vascular Access/Monitoring Equipment</u>	
Armboard: long	2 each
Armboard: short	2 each
Blood glucose monitoring device	1 each
Blood pressure cuff - adult	1 each
Blood pressure cuff - pediatric	1 each
Blood tubes (glucose)	1 each
IV administrations sets: Macro drip, Micro drip	1 each
IV tourniquets	2 each
Needles: IV scalp vein - 19 gauge	2 each
IV scalp vein - 21 gauge	2 each
IV scalp vein - 23 gauge	2 each
IV cannula - 14 gauge	2 each
IV cannula - 16 gauge	2 each
IV cannula - 18 gauge	2 each
IV cannula - 20 gauge	2 each
Syringes: 1cc, 3cc, 5cc, 10cc, 20cc	3 each

Approved:



Administrator



Medical Director

SUBJECT: **ALS First Responder Inventory**

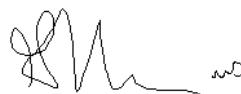
Date: 7/1/02

Stethoscope		1 each
B. <u>Splinting Devices:</u>		
Extrication Collars, Rigid		1 each
Restraints, soft or leather		1 set
Traction Splint		1 each
C. <u>Packs:</u>		
Cold packs		2 each
Drug Box		1 each
Hot packs (warming, not to exceed 110 degrees F)		1 each
Personal Protective Equipment (masks, gloves, gowns, shields)		2 each
Trauma Box/Pack		1 each
D. <u>Other:</u>		
Thermometer-oral, rectal		1 each
E. <u>Communication Items:</u>		
Agency radio		1 each
Broselow Tape		1 each
Communication Failure Protocol (laminated)		1 each
Pediatric Drug Chart (laminated)		1 each
Standing Order Protocol (laminated)		1 each
EMS radio		1 each
F. <u>Replaceable Medications:</u>		<u>Minimum</u>
Adenosine	6mg/2ml vial	6 vials
Albuterol	2.5mg/3ml or 0.083%	6 vials
Atropine sulfate	1mg/10ml	3 each
Atrovent	2.5ml (one unit dose vial) or 0.02%	2 each
Dextrose, 50%	50 ml	2 each
Epinephrine: 1:1,000	1 mg	6 each
Epinephrine: 1:10,000	1 mg	6 each
Lidocaine	100 mg	3 each
Naloxone HCL (Narcan)	2mg/ml	1 each
Nitroglycerine:	0.4 mg	1 container
Versed (Midazolam)	10 mg (2ml)	4 vials
<u>IV Solutions</u>		
Normal Saline - 1000 ml bag		2 each

Approved:



Administrator



Medical Director

SUBJECT: **ALS First Responder Inventory**

Date: 7/1/02

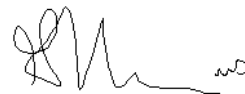
Normal Saline - 250 ml bag	2 each
G. <u>Optional Equipment:</u>	
Conductive gel	1 tube
Defibrillator (combination scope and defib) (strongly advised)	1 each
Defibrillator pads (strongly advised)	2 packages
Electrodes (strongly advised)	1 box
Electrode wires (strongly advised)	2 sets
Pneumatic Anti-Shock Garment (PASG)*	1 each

* Strongly recommended for units with > 15 minute transport time.

Approved:



Administrator



Medical Director

SUBJECT: PUBLIC SAFETY-DEFIBRILLATION SERVICE PROVIDER DESIGNATION

Date: 07/01/03

-
- I.** Authority: Health and Safety Code, Division 2.5, Sections 1797.170, 1797.201, 1797.204 and 1797.220.
- II.** Purpose: To establish a standard mechanism for approval and designation as a Public Safety Defibrillation (PS-D) Provider in San Diego County.
- III.** Policy: San Diego County shall approve and designate PS-D Providers who meet established criteria.
- IV.** Procedure:
- A. Submit a written request for approval to the Medical Director, Division of Emergency Medical Services to include:
1. Description of intended use and population served.
2. Agreement with a Base Hospital for medical control.
- B. The Division of Emergency Medical Services shall review all information submitted. Agencies shall be notified in writing of approval or disapproval within thirty (30) days from receipt of request.
- C. Approved PS-D provider agencies shall enter into a Memorandum of Agreement with San Diego County for PS-D services.

Approved:



Administration



Medical Director

SUBJECT: ESOPHAGEAL TRACHEAL AIRWAY DEVICE SERVICE
PROVIDER DESIGNATION

Date: 2/15/99

-
- I. **Authority:** Health and safety Code, Division 2.5, Sections 1797.170, 1797.204, and 1797.22.
- II. **Purpose:** To establish a standard mechanism for approval and designation as an Esophageal Tracheal Airway Device (ETAD, or “Combitube^R”) provider in San Diego County.
- III. **Policy:** San Diego County shall approve and designate ETAD providers which meet established criteria.
- IV. **Procedure:**
- A. Documentation of current EMT-D program approval from County of San Diego, Division of Emergency Medical Services (EMS).
 - B. Enter into a Memorandum of Agreement with the County of San Diego for ETAD services within the particular area of jurisdiction.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AMBULANCE PROVIDER'S PERMIT APPLICANT PROCESS

Date: 07/01/03

-
- I. **Authority:** California Vehicle Code, Section 2512(c); Health and Safety Code, Division 2.5, Section 1797.204.
- II. **Purpose:** To establish the process by which agencies desiring to provide ambulance service in San Diego County would obtain an Ambulance Provider's Permit.
- III. **Procedure:**
- A. **Application Process, Privately Owned Companies:**
1. Submit a completed application, which contains the following information:
 - a. Names and addresses of the applicant registered owner(s), partner(s), officer(s), director(s), and all shareholders that hold or control 10% or more of the stock of the applicants.
 - b. Applicant's training and experience in the transportation and care of patients.
 - c. Name(s) under which the applicant has engaged, does, or proposes to engage in ambulance service.
 - d. Description of each ambulance including: the make, model, year of manufacture, vehicle identification number, current state license number, the current odometer reading of the vehicle and the color scheme, insignia, name monogram and other distinguishing characteristics of the vehicle.
 - e. Statement that the applicant owns or has under his/her control, in good mechanical condition, required equipment to consistently provide quality ambulance service, and that the applicant owns or has access to suitable facilities for maintaining his/her equipment in a clean and sanitary condition.
 - f. Description of the company's program for maintenance of the vehicles.
 - g. Comprehensive list of on-board communication devices (e.g. radio frequencies and cellular phone numbers).
 - h. Description of all posting locations, noting hours of operation, from which ambulance services will be offered.
 - i. A list of all ambulance drivers and attendants which identifies each persons' EMT certification number and issuing county; CPR certifications, California Drivers License and Ambulance Drivers Certificate, with expiration dates of each.
 - j. Description of the company's orientation program for attendants, dispatchers and drivers.

Approved:



Administration



EMS Medical Director


SUBJECT: AMBULANCE PROVIDER'S PERMIT APPLICANT PROCESS

Date: 07/01/03

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- k. Statement of legal history of all the persons identified in A.1.a above.
 - l. Evidence of insurance for general and professional liability, and worker's compensation in amounts as specified in the San Diego County Ambulance Ordinance.
 - m. An affirmation that the applicant possesses and maintains currently valid California Highway Patrol Inspection certificates for each vehicle listed in the application, and a copy of the license issued by the Commissioner of the California Highway Patrol.
 - n. A completed set of fingerprint cards for each of the persons identified in A.1.a above.
- 2. Agency and inspection fees shall be submitted to the Permit Officer/EMS Chief at the time of application.
 - 3. Within thirty (30) days of receipt of an application, the Permit Officer/EMS Chief shall review all materials submitted and make a determination regarding the issuance of the applied for permit, pending required inspections.
- B. Application Process, Not for Profit/Volunteer
- 1. Submit a completed application as identified in Section A.1 above.
 - 2. Not for profit/volunteer agencies are exempted from the fee requirements identified in Section A.2 above.
- C. Application Process, Governmental Agencies
- Governmental agencies which operate an ambulance twenty-four (24) hours per day with full time paid employees are exempted from the application and fee requirements identified in this policy.
- D. Application Process, Renewal, Privately Owned Companies and Not for Profit/Volunteer
- 1. Submit a completed application, which verifies the information identified in Section A.1 (a-n).
 - 2. Submit appropriate, required fees.
 - 3. Upon approval of the renewal application, the Permit Officer/EMS Chief shall schedule an inspection of all agency service units.
- E. Denial/Revocation of Permit and Appeal Process
- 1. Any false or misleading statements made by the principals, in the application, reports or other documents filed with the Permit Officer/EMS Chief.
 - 2. The applicant is not the legal owner or operator of the service.

Approved:


Administration


EMS Medical Director

SUBJECT: AMBULANCE PROVIDER'S PERMIT APPLICANT PROCESS

Date: 07/01/03

-
3. The applicant was previously the holder of a permit that has been suspended.
 4. The applicant acted in the capacity of a permitted person or firm under this Division without having a valid permit.
 5. The applicant pled guilty, or was found guilty of a felony or crime involving moral turpitude.
 6. The applicant violated any provisions of this ordinance.


Appeal Process

- a. The Permit Officer/EMS Chief shall notify the applicant in writing of the denial within 30 days of the receipt of the application.
- b. The denial shall be written and sent to the last known address of the applicant, or hand delivered to the applicant, and shall set forth the reasons for the denial or revocation.
- c. The applicant may request a hearing from the Permit Officer/EMS Chief by:
 - 1) The request will be in writing.
 - 2) The request must be filed with the Permit Officer/EMS Chief within ten (10) days of the hand delivery of the denial, or fifteen (15) days of mail delivery.
- d. The Permit Officer/EMS Chief must schedule the hearing no later than twenty (20) days after the receipt of the request from the agency.
- e. The decision of the Permit Officer/EMS Chief is final.

Approved:



Administration



EMS Medical Director

SUBJECT: PERMIT APPEAL PROCESS

Date: 6/1/93

- I. **Authority:** San Diego County Code of regulatory Ordinances, Division 10 chapter 4.
- II. **Purpose:** To establish the procedure for the resolution of appeals regarding either the denial of issuance of a permit, or the suspension/revocation of an existing Permit.
- III. **Procedure:**
- A. **Denial of Issuance of Permit:**
- Whenever the Permit Officer denies an application for a Permit, the applicant may request a hearing on the denial.
1. All requests for a hearing shall be submitted in writing to the Permit Officer within ten (10) days of personal delivery of notice of denial of application. If the notice of denial is mailed, applicant has an additional five (5) days to file a hearing request.
 2. A hearing shall be held not more than twenty (20) days from the date of receipt of the applicant's written request for a hearing.
 3. The applicant shall have the burden of proof during the hearing.
 4. The Permit Officer shall issue a decision on all appeals within two (2) working days of the hearing.
 5. The applicant shall be notified in writing of the decision.
 6. The applicant may appeal the denial after the hearing with the Permit Officer.
- B. **Suspension/Revocation of Permit:**
- Whenever the Permit Officer suspends or revokes a current permit, the permittee may request a hearing on the suspension or revocation.
1. All requests for an appeal hearing shall be submitted to the Clerk of the Board of Supervisors in writing within ten (10) days of notification of suspension or revocation.
 2. The Clerk of the board of Supervisors shall assign the appeal to a Hearing Officer selected by the Clerk of the Board of Supervisors on a rotating basis from a list of qualified Hearing Office approved by the Board of Supervisors.
 3. A Hearing Officer shall schedule a date for the hearing within ten (10) days after the date of assignment of the appeal by the Clerk of the Board of Supervisors.
 4. The hearing shall be held no more than thirty (30) days from the time of assignment by the Clerk of the board of Supervisors to the Hearing Officer

Approved:



Administration



Medical Director

SUBJECT: PERMIT APPEAL PROCESS

Date: 6/1/93

5. The hearing Officer is authorized to issue subpoenas, to administer oaths and to conduct the hearing on the appeal.
6. The Permit Officer and the appellant may present evidence relevant to the denial, suspension, revocation, or other decision of the Permit Officer.
7. The Hearing Officer shall receive evidence and shall rule on the admissibility of evidence and on questions of law.
8. At the hearing any person may present evidence in opposition to, or in support of appellant's case.
9. The Hearing Officer shall issue a decision on all appeals at the close of the hearing.
10. The Hearing Officer shall within five (5) days of the announcement of a decision file with the clerk of the Board of Supervisors written findings of fact and conclusion of law and the decision.
11. The decision of the Hearing Officer is final when filed with the Clerk of the Board of Supervisors.
12. The effect of a decision to suspend or revoke a permit shall be stayed while an appeal to the Board of Supervisors is pending or until the time for filing such appeal has expired.

C. Exception to Hearing Procedure:

When in the opinion of the Permit Officer, there is a clear and immediate threat to the Safety and protection of the public; the Permit Officer may suspend a permit without a hearing.

1. The Permit Officer shall prepare a written notice of suspension.
2. The notice of suspension shall be either sent by certified mail or be personally delivered.
3. The Permittee may request a hearing from the Permit Officer within five (5) days of receipt of the notice.
4. The hearing shall be held not more than fifteen (15) days from the date of receipt of the request.
5. Following the hearing, the Permittee affected may appeal the decision in the manner indicated in Section III. B., (1-11) above.
6. The decision shall not be stayed during pendency of such hearing or appeal.

Approved:

Gail F Cooper

Administration

M. L. G. Allen MD

Medical Director

SUBJECT: GROUND AMBULANCE VEHICLE REQUIREMENTS

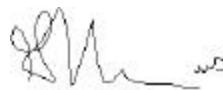
Date: **07/01/03**

- I. Authority:** California Vehicle Code, Section 2512(c); Health and Safety Code, Division 2.5, Section 1797.204.
- II. Purpose:** To define the minimum requirements for ambulance vehicles in San Diego County in the areas of vehicle design, safety equipment, and emergency equipment and supplies.
- III. Policy:** Every ambulance intended for operation in San Diego County shall meet the following minimum requirements:
- A. All ambulances permitted for use in San Diego County shall conform to Federal Specification KKK-A-1822-C as promulgated by the U.S. General Services Administration with the following exceptions:
1. Critical Care Units and Specialty Vehicles may be exempt from Section 3.4.11 Vehicle Physical Dimension Requirements and Section 3.5 Vehicle Weight Ratings and Payload and Section 3.10.8 Doors, provided that it can be demonstrated to the Permit Officer that such exemption does not compromise safety.
 2. Emergency Lighting. Ambulances permitted for use in San Diego County are exempted from Section 3.8.2.1 Emergency Lighting Configuration and Section 3.8.2.3 Switching Arrangements. They will, however, comply with minimum requirements of the California Vehicle Code (CVC) and Regulations promulgated by the State of California and administered by the California Highway Patrol (CHP).
 3. Color, Paint and Finish. Ambulances permitted to operate in San Diego County are exempt from Section 3.16.2 Color, Paint and Finish and Section 3.16.2.1 Color Standards and Tolerances, provided, however, they must comply with California law.
 4. Emblems and Markings. Ambulances permitted to operate in San Diego County are exempt from Section 3.16.4 Emblems and Markings, provided, however, they comply with California law and regulations.
 5. Standard Equipment. Ambulances permitted to operate in San Diego County are exempt from Section 3.15.2 Standard Mandatory Miscellaneous Equipment, Section 3.15.3 Optional Equipment, and Section 3.15.4 Medical Surgical, and Biomedical Equipment, provided they comply with California regulation and local policy.

Approved:



Administration



EMS Medical Director

SUBJECT: **GROUND AMBULANCE VEHICLE REQUIREMENTS**

Date: **07/01/03**

6. Exemptions. The Permit Officer is authorized to grant additional exemptions from Federal KKK-A-1822-C specifications in the following situations:

- a. Declared disaster and disaster recovery periods.
- b. Ambulances in service prior to the effective date of this policy will be granted an exemption for the service life of the ambulance upon submission of documentation that the manufacturer of the ambulance carries at least \$1,000,000 product liability insurance.
- c. Specialty Vehicles such as neonatal transfer units, multiple casualty units and special terrain vehicles may be exempted from specific Sections KKK-A-1822-C provided that the exemptions are shown to be in the interest of patient care and do not unnecessarily compromise safety. Such vehicles may not be placed in service until a permit is issued.

B. Required Documentation:

1. A current and valid San Diego County ambulance license (or facsimile) in the driver compartment.
2. A current and valid San Diego County ambulance license decal affixed to the lower portion right rear of the ambulance.
3. Proof of passage of the annual inspection performed by the CHP within the preceding twelve (12) months.
4. Vehicle registration and proof of insurance as required by law.

C. Emergency Care Equipment and Supplies: The following items shall be carried on all Ground ambulances as a minimum:

1. Essential equipment and supplies as required by the California Code of Regulations, Title 13, Section 1103.2(a) 1-19 (Attachment A).
2. Equipment necessary to comply with California Occupational Safety and Health Administration (CAL-OSHA) standards for exposure to blood borne pathogens.

3. Communication Items: Minimum

Agency Dispatch Device	1 each
Regional Communication System (RCS) 800 MHz programmed with appropriate EMS fleet map.	1 each

Approved:



Administration



EMS Medical Director

SUBJECT: REQUIREMENTS FOR GROUND CRITICAL CARE
TRANSPORT SERVICES

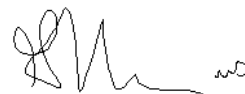
Date: 07/01/02

- I. **Authority:** Health and Safety Code, Sections 1797.220, 1797.222, 1798.172, San Diego County Code of Regulatory Ordinances, Division 10, Chapter 6.
- II. **Purpose:** To identify minimum staffing and equipment requirements for ground critical care transport (CCT) services in San Diego County.
- III. **Definitions:**
- A. CCT Service Provider: any agency that routinely provides for hire the ambulance, personnel and/or equipment utilized to provide CCT services.
 - B. CCT Service: the provision of non 9-1-1 ambulance services utilizing personnel, equipment, medications that provide a higher level of care than that of an ambulance staffed by emergency medical technicians (EMT-Basic or EMT-Paramedic) alone.
 - C. Ground CCT vehicle – ground ambulance providing non 9-1-1 patient care and transport service that is staffed by a registered nurse or physician in addition to EMT-Basic's.
- IV. **Procedure:**
- A. Ground CCT ambulances shall comply with all requirements established for BLS ambulances.
 - B. Each CCT provider agency shall designate a medical director.
 - 1. The medical director shall maintain a valid license as a physician in California.
 - 2. The medical director shall be responsible for all medical protocols and procedures followed by the CCT provider agency's staff.
 - 3. The medical director for the CCT service shall ensure that a comprehensive, written quality assurance (QA)/quality improvement (QI) program is in place to evaluate the medical/nursing care provided to all patients. This QA/QI program shall integrate with the countywide prehospital QA/QI program. Any incidents that result in a

Approved:



Administrator



EMS Medical Director

**SUBJECT: REQUIREMENTS FOR GROUND CRITICAL CARE
TRANSPORT SERVICES**

Date: 07/01/02

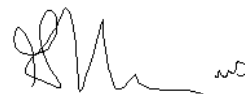
negative patient outcome shall be reported to the San Diego County EMS Medical Director within 10 working days.

4. The CCT provider agency medical director shall ensure that all nursing/medical staff on a CCT collectively possess the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The CCT provider agency medical director shall be accountable for all medical procedures performed on board the CCT by agency staff.
- C. Staffing – CCT providers agencies shall adopt policies requiring the following:
1. All nursing/medical personnel shall maintain current appropriate licensure/certification.
 2. In addition to the ambulance's driver, CCT provider agencies shall routinely staff all CCT vehicles with at least one (1) registered nurse or physician and a second certified or licensed patient care attendant. The requirement for the additional patient care attendant may be waived, on a case by case basis, by the sending physician per written physician order upon consideration of the patient's expected needs during transport.
 3. The nurse shall meet the following qualifications:
 - a. Possess a current California R.N. license.
 - b. Demonstrate clinical competence in resuscitation skills appropriate for age of transported patients (e.g. ACLS, PALS, PEPP, ENPC, NRP).
 - c. Possess two (2) years recent experience in critical care setting (ICU/CCU/ED/CCT).
 - d. Complete a formal orientation program to the CCT provider agency's policies, equipment, medical protocols.
 4. A CCT provider agency shall provide service that is available 24 hours a day/7 days a week.
 5. Nothing in this policy is intended to limit a CCT provider agency from utilizing or maintaining additional staff on board the CCT.

Approved:



Administrator



EMS Medical Director

**SUBJECT: REQUIREMENTS FOR GROUND CRITICAL CARE
TRANSPORT SERVICES**

Date: 07/01/02

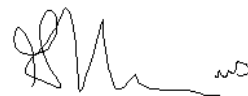
D. Equipment/Medication

1. All CCT ambulances providing service shall carry, as a minimum, the equipment/medication items listed in S-836.
2. Agencies which provide pediatric and/or neonatal transport shall carry the pediatric inventory listed in S-836 (denoted by italics).
3. CCT providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the CCT.
4. Nothing in this policy is intended to limit a CCT provider agency from utilizing or maintaining additional equipment or medications on board the CCT, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.

Approved:



Administrator



EMS Medical Director

SUBJECT: CRITICAL CARE TRANSPORT UNIT INVENTORY

Date: 07/01/02

I. **Authority:** Health and Safety Code, Division 2.5, Section 1797.220, 1797.222, 1798.172
San Diego County Code of Regulatory Ordinances, Division 10, Chapter 6

II. **Purpose:** Identify a minimum standardized inventory on all Basic Life Support and Critical Care Transport Units.

III. **Policy:** Essential equipment and supplies are required by California Code of Regulations, Title 13, Section 1103.2(a)1-20 and/or San Diego County Code of Regulatory Ordinances, Division 10, Chapter 8. Each Basic Life Support or Critical Care Transporting Unit in San Diego County shall carry as a minimum, the following as listed. Additional equipment, medications and supplies may be stocked as needed.

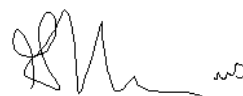
Basic Life Support Requirements:

	<u>Minimum</u>
Ambulance cot and collapsible stretcher	1 each
Straps to secure the patient to the cot or stretcher	1 set
Ankle and Wrist Restraints	1 set
Linens (Sheets, pillow, pillow case, blanket, towels)	2 sets
Oropharyngeal Airways	
Adult	2
Pediatric	2
Infant	1
Newborn	1
Pneumatic or rigid splints	4
Bag-valve-mask w/reservoir and clear resuscitation mask	
Adult	1
Pediatric	1
Infant	1
Oxygen Cylinder w/wall outlet (H or M)	1
Oxygen tubing	1
Oxygen Cylinder - portable (D or E)	2
Oxygen administration mask	
Adult	4
Pediatric	2
Infant	2
Nasal cannulas (clear plastic) Adult	4
Nasal airways (assorted sizes)	1 set
Nebulizer for use w/sterile H ₂ O or saline	2
Glucose Paste/Tablets	1 tube or 10 tablets
Bandaging supplies	
4" sterile bandage compresses	12
3x3 gauze pads	4
2", 3", 4" or 6" roller bandages	6
1", 2" or 3" adhesive tape rolls	2
Bandage shears	1
10"x 30" or larger universal dressing	2
Emesis basin (or disposable bags)	1
Covered waste container	1

Approved:



Administrator



Medical Director

SUBJECT: CRITICAL CARE TRANSPORT UNIT INVENTORY

Date: 07/01/02

Portable suction equipment (30 L/min, 300 mmHg)	1
Suction device - fixed (30 L/min, 300 mmHg)	1
Suction Catheter - Tonsil tip	3
Suction Catheter (6, 8, 10, 12, 14, 18)	1 set
Head Immobilization device	2 each
Spinal Immobilization devices (1 min. 30", 1 min. 60") with straps**	1 each
Cervical collars - rigid	
Adult	3
Pediatric	2
Infant	2
Traction splint *	
Adult or equivalent	1
Pediatric or equivalent	1
Blood pressure manometer & cuff	
Adult	1
Pediatric	1
Infant	1
Obstetrical Supplies to include:	1 kit
gloves, umbilical tape or clamps, dressings, head coverings	
ID bands, towels, bulb syringe, clean plastic bags, sterile	
Scissors or scalpel	
Warm pack, or warming device (not to exceed 110° F)	1
Potable water (1 gallon) or Saline (2 liters)	1
Bedpan	1
Urinal	1
Disposable gloves - non-sterile	1 box
Disposable gloves – sterile	4 pairs
Cold packs	2
Sharps container (OSHA approved)	1
Agency Radio	1
EMS Radio	1

Optional Item:

Positive Pressure Breathing Valve, Maximum flow 40 Liters/min.	1
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Critical Care Transport Requirements:

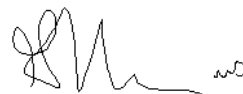
All supplies and equipment in Basic Life Support Requirements in addition to the following:

A. <u>Airway Adjuncts:</u>	<u>Minimum</u>
Aspiration based endotracheal tube placement verification devices	2
End Tidal CO ₂ Detection Devices (<15kg, ≥15kg)	2 each
Esophageal Tracheal Airway Device (Combitube):Reg, Sml Adult**	2 each
ET Adapter	1 setup
Feeding Tube - 8 French	1
Mask - Bag-valve-mask Neonate size <u>(Mandatory only for neonate CCT)</u>	1
1 each	

Approved:



Administrator



Medical Director

SUBJECT: CRITICAL CARE TRANSPORT UNIT INVENTORY

Date: 07/01/02

B. Vascular Access/Monitoring Equipment

Armboard: Long	1
Armboard: Short	1
Blood Glucose Monitoring Device**	1
Infusion pump & supplies	1
<i>Intraosseous kit</i>	1
IV Administration Sets: Macro drip	6
Micro drip	3
IV Tourniquets	4
Needles: IV Cannula - 14 Gauge	3
IV Cannula - 16 Gauge	3
IV Cannula - 18 Gauge	3
IV Cannula - 20 Gauge	3
<i>IV Cannula - 22 Gauge</i>	3
<i>IV Cannula - 24 Gauge</i>	3
IM - 21 Gauge X 1"	3
S.C. 25 Gauge X 3/8"	3
Syringes: 1 ml, 3 ml, 10 ml, 20 ml	3 each

C. Monitoring

Conductive Defibrillator pads	2 pkgs
Defibrillator/ Scope Combination	1
Defibrillator Paddles (4.5 cm, 8.0 cm)	1 pair each
Electrodes	1 box
Electrode Wires	1 set
External pacing equipment and supplies	1 set
Oxygen Saturation Monitoring Device **	1
Adult probe	1
<i>Infant/Pediatric probe</i>	1

D. Packs

Drug Box	1
Personal Protective Equipment (masks, gloves, gowns, shields)	2 sets

E. Other Equipment

<i>Broselow Tape</i>	1
Thermometer - Oral, Rectal	1 each
Water Soluble Lubricant	1

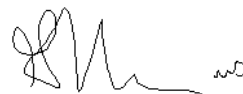
Optional items:

Endotracheal Tubes: Sizes:	
2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 (<i>uncuffed</i>)	1 each
6, 6.5, 7, 7.5, 8, 8.5, 9 (<i>cuffed</i>)	1 each
Laryngoscope - Handle	2
Laryngoscope - Blade: <i>curved and straight sizes 0-2</i>	1 each
<i>curved and straight sizes 3-4</i>	1 each

Approved:



Administrator



Medical Director

SUBJECT: CRITICAL CARE TRANSPORT UNIT INVENTORY

Date: 07/01/02

Magill Tonsil Forceps <i>small and large</i>	1 each
Stylet <i>6 and 14 French, Adult</i>	

F. Replaceable Medications:

Adenosine	6 mg/2 ml vial	6 vials
Albuterol	2.5 mg/3 ml or 0.083%	6 vials
ASA, chewable	80 mg	6
Atropine Sulfate	1 mg/10 ml	3
Atropine Sulfate	multidose 0.4 mg/ml	1
Atrovent	2.5 ml (1 unit dose vial) or 0.02%	2
Bacteriostatic water	30 ml	1
Calcium Chloride	1 GM/10 ml	1
Dextrose, 50%	25 GM/50 ml	2
Diphenhydramine HCL	50 mg/2 ml	2
Dopamine HCL	400 mg	1
Epinephrine	1:1,000 multidose vial	1
Epinephrine	1:1,000 (1 mg/1 ml vial)	3
Epinephrine	1:10,000 (1 mg/10 ml vial)	3
Furosemide	20 mg/40 mg/100 mg vial	100mg total
Glucagon	1 ml (1 unit)	1
Lidocaine HCL	100 mg/5 ml (2%)	3
Lidocaine	(1GM or 2GM)	1
Magnesium Sulphate	5 GM	5 G
Naloxone HCL (Narcan)	2 mg/1 ml	2 each
Nitroglycerin:	0.4 mg	1 container
Nitroglycerin topical preparation	2%	1 tube
Normal Saline for injection	10ml vial	1
Oxytocin (Pitocin)	10 units/1 ml	2
Procainamide	1 GM	1
<i>Sodium Bicarbonate</i>	<i>10 mEq</i>	1
Sodium Bicarbonate	50 mEq/50 ml	2
Solumedrol	125mg	1
Verapamil HCL	5 mg	2
Anticonvulsant (e. g. Valium, Versed or Ativan)	1	QS
<u>IV Solutions:</u>		
Normal Saline	1000 ml bag	2
Normal Saline	250 ml bag	2
D5W	250 ml bag	2

Note: *Pediatric required supplies denoted by italics and are required inventory for units transporting pediatric and neonatal patients.*

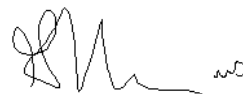
** Unit may remain in service until item replaced or repaired.

* One splint may be used for both adult & pediatric e.g. Sager Splint

Approved:



Administrator



Medical Director

**SUBJECT: NON-EMERGENCY MEDICAL TRANSPORT WHEEL CHAIR/GURNEY VAN
PROVIDER'S PERMIT APPLICATION PROCESS**

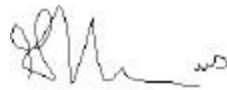
Date: 07/01/03

- I. Authority:** San Diego County Code of Regulatory Ordinances, Division 10, Chapter 3.
- II. Purpose:** To establish the process by which agencies desiring to provide non-emergency medical transport wheel chair/gurney van services in San Diego County would obtain a Non-Emergency Medical Transport Service Provider's Permit.
- III. Policy:** Any agency desiring to provide non-emergency medical transport service in San Diego County shall obtain a San Diego County Non-Emergency Medical Transport Provider's Permit.
- A. Agencies who presently operate non-emergency medical transport services which are currently permitted by the Metropolitan Transit Development Board (MTDB), North County Transit District (NCTD), or any other municipality and are in compliance with the requirements of these agencies will be issued a San Diego County Non-Emergency Medical Transport Provider's Permit without further investigation or fee upon submission of a copy of a current certificate of compliance.
- B. Social service agencies who contract with any organization or entity that is permitted by entities defined in Section III A. shall be issued a San Diego County Non-Emergency Transport Provider's Permit without further investigation or fee.
- IV. Procedure:**
- Application Process, Non-Exempted Agencies By Endorsement of the MTDB Permit
- A. Submit a completed application which contains the following information:
1. Copy of completed and approved MTDB paratransit application.
 2. Copy of approved MTDB vehicle inspection reports and vehicle medallion numbers.
 3. Names and addresses of the applicant, registered owner(s), partner(s), officer(s), director(s) and all shareholders who control 10% or more of the stock of the applicant.
 4. Name under which the applicant has, does or proposes to engage in non-emergency medical transport service.
 5. A resume specifying the education, training and experience of the applicant in the business of providing transportation services.

Approved:



Administration



EMS Medical Director

**SUBJECT: NON-EMERGENCY MEDICAL TRANSPORT WHEEL CHAIR/GURNEY VAN
PROVIDER'S PERMIT APPLICATION PROCESS**

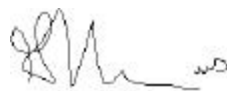
Date: 07/01/03

6. A description of each gurney van and/or wheelchair van including the make, model, year of manufacture, vehicle identification number, the current odometer reading of the vehicle and the color scheme, insignia, name, monogram or other distinguishing characteristics of the vehicle.
 7. A description of the company's program for maintenance of the vehicles.
 8. Proof of ability to staff each vehicle with person(s) possessing at least a current American Red Cross Standard First Aid Certification, or equivalent.
 9. A Certificate of Consent to Self Insure issue by the California State Director of Industrial Relations, or a Certificate of Worker's Compensation Insurance as required.
 10. Proof of liability insurance as required.
 11. A statement of the legal history of the applicant, registered owner(s), partner(s), officer(s), director(s) and controlling shareholder, including criminal convictions and civil judgments.
- B. Permit by direct application to the County.
1. Completed County non-emergency vehicle permit application.
 2. Applicant's name and business address.
 3. (Refer to Section A. #3 through 10 above.)
- C. Submit appropriate required fee to the Permit Officer at the time of application.
- D. Within thirty (30) days of receipt of an application, the Permit Officer will:
1. Make a determination regarding the issuance of the applied for permit.
 2. Once application is accepted, schedule inspection and permitting of all service units.

Approved:



Administration



EMS Medical Director

**SUBJECT: NON-EMERGENCY MEDICAL TRANSPORT WHEEL CHAIR/GURNEY VAN SERVICE
REQUIREMENTS**

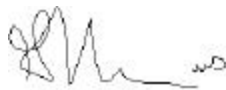
Date: 07/01/03

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- I. Authority:** San Diego County Code of Regulatory Ordinances, Division 10, and Section 610.702.
- II. Purpose:** To define the minimum requirements for non-emergency medical transport wheel chair/gurney van service in San Diego County in the areas of vehicle design, safety equipment and supplies.
- III. Policy:** Every non-emergency medical transport service vehicle intended for operation by an approved provider in San Diego County shall meet the following minimum requirements:
- A. All non-emergency medical transport service vehicles, shall at all times:
1. Comply with all applicable federal, state, and local licensing requirements.
 2. Be configured, licensed, and maintained pursuant to all federal and state laws, and local policies.
 3. Have an exterior color scheme and company name/logo sufficiently distinctive so as to not cause confusion with vehicles from other agencies or medical transport services, as determined by the Permit Officer.
- B. Required documentation:
1. A current and valid San Diego County Non-Emergency Medical Transportation Service license decal affixed to the lower portion right rear of the vehicle.
 2. Proof of passage of the mechanical inspection performed by the County specified contracted provider within the preceding six (6) months. Agencies currently permitted by regulatory entities identified in the San Diego County Code of Regulatory Ordinances, Division 10, Chapter 3, Section 610.301 (a.b.c.) shall present proof of passage of a mechanical inspection within the preceding twelve (12) months.
 3. Prove and maintain in full force and effect liability insurance including, but not limited to, comprehensive auto liability, each with a combined single limit of not less that \$1,000,000 per occurrence, and general liability with a limit of not less that \$1,000,000 per claim.
 4. Proof of Workers Compensation or a Certificate of Consent to Self-Insure issued by the California State Director of Industrial Relations, applicable to all employees. The Permittee must maintain in full force and effect such coverage during the term of the Permit.

Approved:



Administration



EMS Medical Director

**SUBJECT: NON-EMERGENCY MEDICAL TRANSPORT WHEEL CHAIR/GURNEY VAN SERVICE
REQUIREMENTS**

Date: 07/01/03

C. Personnel Standards:

1. Each driver shall possess at least a current American Red Cross Standard First Aid Certification or equivalent.
2. Each driver shall be at least eighteen (18) years old and possess a valid California Driver's License, designated class III/C or higher.
3. No person shall act in the capacity of a non-emergency medical transportation driver or Attendant if such person is required by law to register as a sex offender or has been convicted of any criminal offense involving force, duress, threat, or intimidation within the last five (5) years.
4. All drivers shall wear clean uniforms that identify the employer or sponsoring agency, and have visible identification of name.
5. Each driver shall wear, in a manner clearly visible on their person a driver identification card issued by the Metropolitan Transit Development Board (MTDB).

D. Required Equipment and Supplies:


The following items shall be carried on all non-emergency transport service vehicles as a minimum:

1. A fire extinguisher of the dry chemical or carbon dioxide type with an aggregate rating of at least five (5) B/C units and a current inspection card affixed to it.
2. A minimum of at least three (3) red emergency reflectors.
3. A first-aid kit containing medical items to adequately attend to minor medical problems.
4. A map of the County of San Diego published within the past two (2) years, which shall be displayed to any passenger upon request.
5. Each vehicle shall be equipped with a rear view mirror affixed to the right side of the vehicle, as an addition to those rear view mirrors otherwise required by the California Vehicle Code.
6. Each vehicle shall be equipped with a rear view mirror affixed in such a way as to allow the driver to view the passengers in the passenger compartment.

Approved:



Administration



EMS Medical Director

**SUBJECT: NON-EMERGENCY MEDICAL TRANSPORT WHEEL CHAIR/GURNEY VAN SERVICE
REQUIREMENTS**

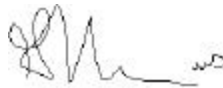
Date: 07/01/03

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7. Each vehicle identified in #6 above shall have at least one (1) oxygen tank floor mount-securely mounted, for each oxygen cylinder present on the vehicle.
 8. Each vehicle shall have a vehicle body number visible on the left front, right front and rear portion of the vehicle.
 9. Each vehicle shall have an operational 2-way agency communication device.
 10. Each vehicle shall carry wheel chair seat belts for each wheel chair position in the vehicle.
 11. Each vehicle shall have the appropriate number of approved wheel chair restraint mechanisms.
 12. Each vehicle shall have floor mounts for the wheel chair tie downs – securely mounted.
 13. Each vehicle shall have seat belts for all seats used by ambulatory clients.
 14. Each vehicle shall have a minimum of one (1) blanket on board.
 15. Each vehicle shall carry all equipment necessary to comply with California Occupational Safety and Health Administration (CAL OSHA) standards for exposure to blood borne and air borne pathogens.
 16. Each vehicle shall carry one (1) extra wheel chair.

Approved:



Administration



EMS Medical Director

SUBJECT: BASIC LIFE SUPPORT AMBULANCE SERVICE PROVIDER REQUIREMENTS

Date: 1/1/95

- I. Authority:** Health and Safety Code 1797.160, 1797.204 and 1797.220, 1797.214 California Vehicle Code, Article 2, Section 2512(c). San Diego County Code of Regulatory Ordinances, Division 10.
- II. Purpose:** To assure minimum requirements for basic life support (BLS) ambulance services operating in San Diego County.
- III. Policy:** To be eligible to provide BLS ambulance service in San Diego County, an agency (public or private) shall:
1. Maintain appropriate licensure as required by the California Highway Patrol.
 2. Maintain appropriate permit as required by the San Diego county Code of Regulatory Ordinances, Division 10, Chapter 2.
 3. Staff each transporting unit responding to call for service with a minimum of two (2) Emergency Medical Technician-1 (EMT-1) currently certified in the State of California.
 4. Be in accordance with the San Diego County Emergency Medical Service (EMS) policies and procedures.
 5. Cooperate with the EMT training agencies in providing field experiences.
 6. Establish internal quality assurance mechanisms based on policies/procedures as cited by the San Diego County Division of EMS, including participation in Countywide monitoring activities. (See policy S-004)
 7. Submit completed prehospital reports in accordance with policy S-602.
 8. Meet all requirements as identified in California Code of Regulations, Article I, Section 1100.3, California Vehicle Code, Article 2, Section 2512 (b), (c) and (d), and San Diego County Code of Regulatory Ordinances, Division 10, Chapter 6.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: **AEROMEDICAL CLASSIFICATION**

Date: 9/1/91

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- I. Authority:** Health and Safety Code 1792.201 and 1797.206.
- II. Purpose:** To establish criteria for classification of aeromedical service providers operating within the emergency medical services (EMS) system of the County of San Diego.
- III. Policy:** All aeromedical aircraft operating within the San Diego County EMS system shall be classified by the Division of EMS prior to operation. Reclassification shall occur if there is a transfer of ownership or a change in the aircraft's category. Classifications shall be as follows:
1. Air ambulance - any aircraft specially constructed, modified or equipped, and used for primary purpose of responding to emergency medical calls. Staffed with a minimum of two (2) attendants certified to provide advanced life support (ALS).
 2. Rescue aircraft - any aircraft not primarily used for emergency medical transports but which may be used for that purpose when air or ground ambulance is inappropriate or unavailable.
 - A. ALS rescue aircraft - a rescue aircraft whose medical flight crew has at a minimum one (1) attendant certified to provide ALS.
 - B. BLS rescue aircraft - a rescue aircraft whose medical flight crew has at a minimum one (1) attendant certified as an EMT-1A.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AEROMEDICAL DISPATCH CENTER DESIGNATION

Date: 9/1/91

-
- I. **Authority:** Health and Safety Code, Section 1797.204, 1797.206, 1797.218.
- II. **Purpose:** To Provide for the coordination of EMS aircraft response within San Diego County.
- III. **Policy:** All EMS Aeromedical service providers operating within San Diego County shall be dispatched by a center designated by the Division of EMS.
- A. To be designated as an aeromedical dispatch center, the dispatch agency shall:
1. Be staffed 24 hours a day, 7 days a week.
 2. Possess radio capabilities allowing for constant communication with aircraft.
 3. Have a dedicated landline for response requests.
 4. Provide upon request, within thirty (30) days of incident, tapes needed for quality assurance purposes.
 5. Possess landline communication capabilities with all receiving hospitals.
 6. Maintain a flight log to include, at a minimum:
 - a. time of request
 - b. requesting agency
 - c. location of incident
 - d. time dispatched
 - e. crew on board
 - f. time of lift off
 - g. time arrived on scene
 - h. time of lift off from scene
 - i. time arrived at receiving hospital
 - j. reason for aborted flight
 7. Comply with the Division of Emergency Medical Service in the quality assurance process.
- B. The County of San Diego may revoke or suspend authorization of an EMS aircraft designated dispatch center for failure to comply with applicable policies, procedures, protocols and regulations

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AEROMEDICAL DISPATCH CENTER DESIGNATION

Date: 9/1/91

IV. Procedure:

- A. Dispatch centers requesting aeromedical dispatch designation must submit a written request to the County of San Diego, Division of EMS the following minimum information:
1. Communication capabilities with all hospitals, all public safety agencies, BLS and ALS ground units; aeromedical units.
 2. Location of all landing sites.
 3. Documentation of compliance with applicable Federal and State Air Regulations.
- B. County of San Diego County, Division of EMS may revoke/suspend designation of dispatch center for failure to comply with applicable policies, procedures, protocols and regulations.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: **AEROMEDICAL SERVICE PROVIDER AUTHORIZATION**


Date: 9/1/91

- I. Authority:** Health and Safety Code, Section 1797.204, 1797.206 and 1797.218.
- II. Purpose:** To define the process for authorization of aeromedical service provider agencies operation by Division of Emergency Medical Services (EMS) within the San Diego County.
- III. Policy:** All areomedical service provider agencies operating within the San Diego county EMS system shall be authorized by the Division of Emergency Medical Services prior to operation.
- A. To be authorized to provide EMS areomedical support the provider shall:
1. Provide services on a continuous twenty four (24) hour basis, and
 2. Maintain medical flight crews as provided for by each aircraft classification, and
 3. Function under local medical control, and
 4. Comply with the Division of Emergency Medical Services quality assurance process to include representative participation on the Prehospital Audit committee, and
 5. Submit prehospital reports as per County of San Diego division of EMS policy S-602, and
 6. Participate in community education programs and first responder orientation when requested, and
 7. Submit to the Division of EMS evidence of compliance with California Code of Regulations, title 22, Division 9, Chapter 8, Section 100302 (Medical Flight Crew Personnel Training) and 100306 (Space and Equipment), and
 8. Enter into a written agreement with the County as an areomedical service provider, and
 9. Submit to the Division of EMS verification of dispatch capability, 24 hours a day, 7 days a week, capable of maintaining constant communication with the aircraft, and
 10. Comply with all applicable Federal and State Air Regulations.
- B. The County of San Diego may revoke or suspend authorization of an aeromedical provider for failure to comply with applicable policies, procedures, protocols and regulations.
- IV. Procedures:**
- A. Agencies requesting authorization must submit a written request to the County of San Diego, Division of EMS include, but not be limited to:

Approved:



Administration



Medical Director

SUBJECT: AEROMEDICAL SERVICE PROVIDER AUTHORIZATION

Date: 9/1/91

1. Number and type of aircraft to be authorized.
 2. Patient capacity of each aircraft.
 3. Level of patient care to be provided by each aircraft.
 4. Proposed staffing for each aircraft.
 5. Statement of demonstration need.
- B. Once authorized; the provider agency shall notify the local EMS agency of
1. Any foreseen or unforeseen change in or disruption of service (i.e., decrease in number of aircraft available, staffing patterns or patient care capabilities).
 2. Documentation of satisfactory compliance with personnel requirements, equipment and supplies.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AIR MEDICAL DISPATCH-PRIMARY RESPONSE ROTORCRAFT


Date: 5/1/97

- I. Authority:** Health and Safety Code, Division 2.5, Section 1797 et. seq., California code of regulations Sections 100302 and 100306, San Diego County Uniform Ambulance Ordinance.
- II. Purpose:** To establish the requirements for central dispatch of primary response rotorcraft (PRR) and procedures for an orderly rotation of operators.
- III. Policy:**
A central dispatch center will be designated by the Division in the event of multiple PRR providers. The need for a central air medical dispatch facility shall be review by the Department of health Services (DHS), Division of Emergency Medical Services (EMS).
- IV. Roles & Responsibilities:**
- A. Department of Health Services, Division of EMS.
1. Identifies capable vendors.
 2. Develops and distributes a Request for Bid (RFB) for central PRR air medical dispatch services.
 3. Evaluates the proposals, and designates an air medical dispatch provider.
- B. Designated air medical dispatch provider provides the following services:
1. Maintains an 800 or 888 (toll free) dedicated telephone line to allow access by all requesting agencies (staffed 24 hours a day)
 2. Answers the phone " Air Medical Service".
 3. Establishes the identity of the caller, confirms the location of the incident, the contact person's name, ground contact radio frequency and other pertinent information.
 4. Determines the closet available helicopter.
 5. Informs the requesting agency of the helicopter's ETA.
 6. Requests launch or standby as appropriate from the closest provider.
 7. Maintains a system status plan approved by the Division of EMS and adheres to the dispatch procedure established in Section V. of this policy.

Approved:



Administration



Medical Director

SUBJECT: **AIR MEDICAL DISPATCH-PRIMARY RESPONSE ROTORCRAFT**

Date: 5/1/97

8. Provides the Division of EMS and participating PRR providers with system reports for each month. These system reports shall illustrate the dispatch times, response times and other patient service times captures by the air medical dispatch center.

C. Air medical service providers shall:

1. Maintain at least one permitted staff primary response rotorcraft on station within the borders of San Diego County at all times (weather permitting). Additional helicopters stationed in or not of the County are also allowed provided that they are permitted and staffed per San Diego regulations.
2. Provide the air medical dispatch center with a true and accurate ETA and other response time data.
3. Respond PRR promptly when a launch is requested.
4. Maintain a separate communications center for the purpose of dispatch, in-flight communication, and flight following.
5. Provide all data necessary to accurately program CAD systems and maintain the system status information.

V. **Dispatch Procedure:**

A. Air medical services request:

1. Requesting agencies contact the air medical dispatch center on the designated phone line to request an air medical launch or standby providing: incident address, Thomas Bros. map page, nature of incident, landing zone, ground contact unit, and coordination radio frequency.
2. Air medical dispatch center selects the closest unit and advises the requesting agency of the unit number, response location and pertinent hospital receiving information.
3. Air medical dispatch center provides information to the selected PRR provider and obtains an ETA.
4. Air medical dispatch center tracks helicopter status as (ALERTED) when a standby is requested and (RESPONDING) when a launch is initiated, air medical dispatch center tracks disposition of the response as cancelled or transport as advised by the PRR provider at the close of each response.

B. Air medical unit selection for responses:

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AIR MEDICAL DISPATCH-PRIMARY RESPONSE ROTORCRAFT

Date: 5/1/97

1. PRR provider land lines the air medical dispatch center with each "on and off duty" status of helicopter units, providing unit numbers, hours and location.
 2. PRR provider land lines designated PRR central dispatch provider with units "out of services" status or post to post moves within the County for various reasons including fueling, special events, etc
 3. Air medical dispatch center selects closest PRR provider based on proximity to the incident. In the instance where multiple providers are at the same post, the PRR provider not having handled the last response will be selected.
- C. Other communications:
1. Pre-launch communication "requests for service" will be made to the air medical dispatch center.
 2. Post-launch communications pertaining to a response in progress should be made directly between the responding PRR provider and the requesting agency.
- D. Posting locations:
1. PRR provider land lines the air medical dispatch center with each "on and off duty" status of helicopter units, providing unit numbers, hours and location.
 2. "Move up" locations may also be used at the discretion of the provider for periods of six hours or less provided that they are at a licensed helipad or airport and that appropriate indoor rests and toilet facilities are provided for flight crews. No itinerant units will be permitted.
- E. Disputes:
1. Selection made by the air medical dispatch center at the time of service shall be final.
 2. PRR providers who believe that a dispatch error has occurred shall present their complaints in writing to the Division of EMS Ambulance Permit Officer within two weeks of the incident.
 3. The Ambulance Permit Officer shall investigate disputed calls and may at his/her discretion compensate an appealing PRR provider agency with an "extra turn or turns" in rotation. No other compensation shall be made and the decision of the Permit Officer is final.

Approved:

Gail F Cooper

Administration

M. L. G. G. G.

Medical Director

SUBJECT: AIR MEDICAL DISPATCH-PRIMARY RESPONSE ROTORCRAFT

Date: 5/1/97

VI. Fees:

A. Dispatch Fee:

1. A dispatch fee shall be assessed for each dispatch resulting in a transport. PRR providers shall be billed monthly.
The amount of the dispatch fee shall be determined by the Board of Supervisors and shall reasonably cover the cost of providing the dispatch service.
2. Fees shall be due and payable to "Division of EMS" or its designee 30 days after the date of invoice.
3. Failure to remit fees within the 30 day period shall result in immediate suspension from the central dispatch program until fees have been paid.
4. Failure to remit fees within 60 days after the date of the invoice shall result in permanent termination from the central dispatch program.

VII. Definitions:

Alert - condition wherein a requesting agency has requested that a PRR be placed on standby in anticipation of a response.

Estimated time of arrival (ETA) - The sum of scramble, pre-flight, launch, and in-flight response time to a scene.

Launch - Condition wherein a requesting agency has requested that a PRR respond to an incident scene.

Primary Response Rotorcraft (PRR) - A helicopter permitted as an air medical ambulance by the Department of Health Services, Division of EMS, staffed and configured per the County Air Medical Service Plan.


Responding - condition wherein the PRR flight crew is leaving quarters, preparing the helicopter for flight and flying to the incident scene.

Response Time - the sum of scramble, preflight, launch, and in-flight response time to a scene.

Approved:



Administration



Medical Director